# Hawthorne Dog and Cat Hospital

14431 Hawthorne Blvd | Lawndale, CA 90260 | Phone 310-675-3328 | Fax 310-675-0910

## Financial Policy

Thank you for choosing Hawthorne Dog and Cat Hospital. Our primary mission is to deliver the best and most comprehensive veterinary care available for your pet. An important part of the mission is making the cost of optimal care as easy and manageable for our clients as possible by offering several payment options. Hawthorne Dog and Cat Hospital requires payment in full at the end of your pet's examination and/or at the time of discharge.

**Payment Options:**

You can choose from:

- Cash, Check, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Plans[1] from CareCredit®
    - Allow you to begin treatment today and pay over time
    - Available for any treatment amount
    - Can be used repeatedly - for your entire family - without having to reapply[1]

For some treatments or hospitalized care, a deposit may be required. Healthcare plans requiring comprehensive care of more than $500 or more, will require a deposit to begin your pet's treatment.

**Additional Policy Information:**

Hawthorne Dog and Cat Hospital charges $25 for returned checks. A fee of $25 may be charged for clients who miss or cancel more than 3 appointments in a calendar year without 24 hours notice. For clients with pet insurance, we are happy to provide you with the necessary documentation to submit a claim to your insurance carrier.

If you have any questions, please do not hesitate to ask. We are here to provide the best veterinary care available for your pet.

By signing below, you agree to the foregoing terms of payment:

_____

Client/Owner Signature Date

_____

Client/Owner Name (Please Print)

_____

Pet Name Breed

[1]Subject to credit approval

UPON SIGNING FINANCIAL POLICY, I ACKNOWLEDGE THAT WHEN SCHEDULING A SURGERY OR A SEDATED PROCEDURE ADDITIONAL TIME IS SET ASIDE TO ATTEND TO MY PET. I AGREE THAT SHOULD I BE UNABLE TO ATTEND THE SCHEDULED SEDATED PROCEDURE OR SURGERY I WILL CALL 24 HOURS PRIOR TO SAID PROCEDURE OR WILL BE REQUIRED TO PAY A $50 DEPOSIT WHEN SCHEDULING THE NEXT SEDATED PROCEDURE OR SURGERY, WHICH WILL BE PUT TOWARDS MY PETS SCHEDULED PROCEDURE. SHOULD I NOT ATTEND SAID PROCEDURE, I THEN FOREFIT MY DEPOSIT AND WILL BE REQIRED TO PAY A NEW DEPOSIT FOR ANY PROCEDURES THEREAFTER.

# After Hours Protocol

Hospital hours are:

| | |
|---|---|
| Monday through Friday | 9:00am- 6:00pm |
| Saturday | 8:00am- 2:00pm |
| Sunday | CLOSED |

*Patients not picked up by closing are subject to a late pick up fee of $35

I have read and agree to the After Hours Protocol:

Sign_____

Print Name _____

-We require your permission prior to giving out information about your pet.
Please check one:

( ) You can give out information about my pet to anyone who calls.

( ) You can give out information about my pet to Veterinarians, Groomers, Boarding Facilities.

( ) Do not give out information about my pet to anyone without my permission.

-Besides myself I , (owner name) _____,
authorize the following people to make medical decisions for my pets if I'm unable to.

Name_____ Relation_____

Phone number_____

# Hawthorne Dog and Cat Hospital

Client/Patient Registration

Date:_____

Owner's Name (Last)_____(First)_____

Spouse:_____

Address_____City:_____Zip:_____

Home Phone:_____Cell:_____Work:_____

Driver's License Number:_____

Date Of Birth:_____

Employer:_____

E-Mail Address:_____

How did you hear about us?_____

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Pet's Name:_____Date Of Birth:_____

Type Of Animal (please circle) Dog Cat

Breed:_____

Color/Markings:_____

Sex (please circle what applies) Male / Neutered Female / Spayed

Date and Type of last Vaccinations:_____

I am aware that payment is due at the time services are rendered, deposit is required for surgical procedures

Signature:_____