PAWSITIVE STRIDES
Veterinary Rehabilitation & Therapy

2911 Ingersoll Avenue
Des Moines, IA 50312
515-575-9655
info@pawsitivestridesdsm.com
pawsitivestridesdsm.com

Client Information Form

Client Information:

Owner's name: _____

Owner's address: _____

City: _____ Zip: _____

Cell/Home phone: _____

Place of employment: _____Phone:_____

Email address: _____

Pet Information:

Pet's name: _____

Age/DOB: _____☐ Dog ☐ Cat ☐ Other: _____

Breed: _____ Color: _____

☐ Male ☐ Female ☐ Spayed/Neutered?

Primary Care Veterinarian or Clinic:_____

Surgeon or Specialist/Hospital: _____

Reason for today's visit: _____

_____

How did you hear about us?

☐ Internet

☐ Friend: _____ (we like to thank them)

☐Vet: _____ (please specify)

☐ Other: _____ (please specify)

Treatment Authorization

I am the owner or agent of the described animal above and have the authority to execute this consent. I hereby authorize the veterinarian and staff of Pawsitive Strides Veterinary Rehabilitation & Therapy/Ingersoll Animal Hospital to examine and render treatment. I also authorize the use of appropriate medical procedures. I realize results cannot be guaranteed. I understand PSVRT reserves the right to reschedule therapy appointments if I am more than 15 minutes late without notice.

Signature:_____ **Date:**_____

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Payment Policy

I understand that cash or credit/debit cards and Care Credit cards are accepted forms of payment. Credit and debit cards are verified electronically. If authorization is declined for any reason on a credit or debit card, another method of payment is required. Full payment is required at the time services are performed. Pets must be picked by closing time or a late fee of $30 will be assessed.

I understand that it is not the practice of Pawsitive Strides Veterinary Rehabilitation & Therapy to keep clients' personal information or credit card number on file. If such occasion should occur, the aforementioned sensitive information will be kept in a locked & secured area of the facility and used with my express consent.

I have carefully read the treatment authorization and payment policy. By signing below, I agree to all conditions.

Signature:_____ **Date:**_____