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## Financial Agreement

First Name:

Last Name:

Mailing Address:

City:

State:

Zip:

Celular Phone:

Home Phone:

Secondary Owner Name:

Phone:

Email: (we use this for confirmations, to send reminders, and occassional communication)

Previous Veterinarian:

How did you hear about us?

Google Phonebook Radio Newspaper Website Facebook Other: \_\_\_\_\_

Whom can we thank for the referral?

\_\_\_\_\_

### ***Financial Agreement***

**Full payment is required at the time of service. By signing below you are acknowledging that you understand our financial policy. I deposit minimum of 50% of the presented estimate is required for all major surgery/hospitalization at admittance.**

**I request that the Animal Clinic of Kalispell staff preform the necessary exam and medical treatment on my pet. I am the owner/responsible party for the animal and have the authority to execute this consent. I am at least 18 years of age. I also understand that a written estimate will be provided at my request. I accept financial responsibility for all charges incurred by my pet for services rendered. I understand full payment is required for my pet to be discharged.**

I prefer to pay with the following method(s):

cash check credit/debit CareCredit Scratchpay

Signature:

\_\_\_\_\_

Driver License #: \_\_\_\_\_

<Office Use Only> PD \_\_\_\_\_ NC \_\_\_\_\_ WC \_\_\_\_\_