

## REGISTRATION FORM

**Centralia Animal Hospital  
4125 Celebration Avenue  
Chester, Virginia 23831  
Tel. 1-804-768-4212**

Owner's Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_.

Address \_\_\_\_\_.

City/State \_\_\_\_\_; Zip Code: \_\_\_\_\_; Email Address: \_\_\_\_\_.

Home Phone No. \_\_\_\_\_ Cell Phone No \_\_\_\_\_.

Employer's Name \_\_\_\_\_; Address \_\_\_\_\_.

City/State \_\_\_\_\_; Zip \_\_\_\_\_, Work Phone: \_\_\_\_\_.

Spouse Name \_\_\_\_\_; Soc. Sec. No. \_\_\_\_\_.

Employer's Name \_\_\_\_\_; Address: \_\_\_\_\_.

City/State \_\_\_\_\_; Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Referred By \_\_\_\_\_;

Pet's Name 1.) \_\_\_\_\_ 2.) \_\_\_\_\_ 3) \_\_\_\_\_

I, being responsible for the animal(s) described above, assume responsibility for all charges resulting from care of this animal. I understand that these charges are due at the time services are provided, and that a deposit may be required for surgical or hospitalization treatment. I also understand that if this contract or any debt owed to Centralia Animal Hospital is referred to an attorney for collection, I agree to pay all attorney fees in the amount thirty three and one-third (33 1/3%) of the total indebtedness, court costs, and a service charge of one and one-half percent (1 1/2%) per month, eighteen percent (18%) per annum.

I also understand that the hospital is only staffed during the approximate hours of:

7:30 AM – 6:30 PM Mon. – Fri. and 8 AM – 12:30 PM Sat. (These hours may vary somewhat based upon schedule changes, holidays, season, and unforeseen circumstances.)

**\*Please note we do not accept checks until after your 6<sup>th</sup> visit**

Method of payment: Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_.

After carefully reading the above, I have signed in agreement.

---

(owner or responsible party)

Date \_\_\_\_\_.