



**FLORIDA VETERINARY HOSPITAL**

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Phone 011 879 1042 Fax 086 684 3161 Email: info@floridavet.co.za www.floridavet.co.za

**NEW CLIENT INFORMATION FORM**

**PERSON RESPONSIBLE FOR ACCOUNT:**

MR  MRS  MISS  DR  OTHER

SURNAME: \_\_\_\_\_

NAME / INITIALS: \_\_\_\_\_

ID NUMBER: \_\_\_\_\_

PHSICAL ADDRESS: \_\_\_\_\_

POSTAL ADDRESS: \_\_\_\_\_

CODE: \_\_\_\_\_

CODE: \_\_\_\_\_

TELEPHONE: (H) \_\_\_\_\_ (WORK) \_\_\_\_\_  
(CELL) \_\_\_\_\_ (OTHER) \_\_\_\_\_  
(CELL) \_\_\_\_\_ (OTHER) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

NAME OF OTHER CONTACT (NOT LIVING AT THE SAME ADDRESS): \_\_\_\_\_

RELATIONSHIP TO THE ABOVE: \_\_\_\_\_

TELEPHONE NO OF THE ABOVE: (CELL) \_\_\_\_\_ (OTHER) \_\_\_\_\_

**PATIENT (PET) INFORMATION:**

NAME: \_\_\_\_\_ BREED: \_\_\_\_\_

COLOUR: \_\_\_\_\_ AGE/DOB: \_\_\_\_\_ GENDER: \_\_\_\_\_

STERILISED: YES  NO  MICROCHIP NO: \_\_\_\_\_

ADDITIONAL REMARKS (ALLERGIES / CHRONIC DISEASES ETC.): \_\_\_\_\_

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COLOUR: \_\_\_\_\_ AGE/DOB: \_\_\_\_\_ GENDER: \_\_\_\_\_

STERILISED: YES  NO  MICROCHIP NO: \_\_\_\_\_

ADDITIONAL REMARKS (ALLERGIES / CHRONIC DISEASES ETC.): \_\_\_\_\_

**Please turn over to read the terms and conditions and to sign.**

**TERMS AND CONDITIONS**

**GENERAL:**

1. I hereby certify that I am the legal owner of all the pets that are listed under my file at this facility from time to time, and that I am liable for all the expenses incurred on their behalf at this facility (this includes any additional pets (not listed above) that may be treated by Florida Veterinary Hospital subsequent to completing this form.)
2. I undertake to ensure that an adult person presents all pets for treatment and am aware that the staff at this facility will be unable to accept instructions for treatment from anyone under 21 years of age.
3. When leaving my pets in the care of others (holidays, overseas trips, hospital etc) I will make provision for a responsible adult person to act on my behalf,
  - 3.1 Giving them express consent to contact with this facility on my behalf regarding treatments, finances, decisions regarding euthanasia etc.
  - 3.2 Enabling them to pay deposits and other payments on my behalf.

Should I fail to make such arrangements, I hereby unconditionally undertake to abide by the decisions made in good faith in my absence by the staff at this facility and declare myself unconditionally responsible for the payment of all professional fees for such treatment.

**PAYMENTS:**

1. I acknowledge that all accounts are payable in full upon presentation of invoice.
2. I undertake to pay a deposit equal to the pre-estimated account prior to hospitalisation and accept that such deposit is an absolute pre-condition for hospitalisation, I will settle any outstanding balance upon presentation.
3. I undertake to enquire as to the extent and approximate costs of a proposed treatment, failing which I unconditionally accept that I am liable for the cost thereof.
4. I hereby consent that the practice may use a National Credit Bureau database for tracing purposes if necessary. Should the responsible party fail to settle their account in full, the practice may record the responsible party's default with the Credit Bureau. In the event of legal proceeding for the recovery of an unpaid account, responsible party will be liable for the payment of legal fees at a rate between Attorney and own client. All parties named herein consent to the jurisdiction of the Magistrate Court should legal Proceedings be necessary for collection of the outstanding amounts.
5. Interest will be charged in accordance with the National Credit Act under incidental debt up to 2% per month on accounts that have not been settled. I understand that payments on outstanding accounts shall be allocated in the following way, interest, costs then capital.
6. In the event that an account is handed over to our debt collection agent for collection, I irrevocably agree to pay for all costs, Legal Counsel on their agreed scale, collection commissions, (including the costs and collection commission of any correspondent agent in connection therewith) and interest thereon at the rate of 2% per month.
7. I irrevocably consent to an Emolument Attachment Order being issued against my current employers and do further undertake to pay any commission that my employers are entitled to deduct.
8. I irrevocably consent to the Jurisdiction of the Johannesburg Magistrate Court or Small Claims Court, and that all performance took place within the jurisdiction of these courts.
9. I consent to sharing information on my account with other credit granters and with the credit bureaux. Information shared with these companies is used only to make credit-granting decisions and to prevent fraud.
10. I hereby confirm that in the event that I fail, neglect or refuse to pay any amount outstanding to Florida Veterinary Hospital cc without valid cause, such cause having been advised to Florida Veterinary Hospital cc, Florida Veterinary Hospital shall be entitled to regard such information as non-confidential and to make such information, together with all other information provided by me to Florida Veterinary Hospital cc whether in terms of this agreement or otherwise to any and all registered veterinarians / veterinary practices and such disclosure shall not constitute publication of confidential information.
11. I undertake to inform the practice of any change of details.
12. The terms and conditions of this form will be applicable if there are any subsequent / repeat procedures and any future procedures / treatment done on any other patients which you may not have listed on this form.

**SHOULD CREDIT HAVE BEEN EXTENDED TO YOU FOR ANY REASON WHATSOEVER, FLORIDA VETERINARY HOSPITAL cc RESERVES THE RIGHT TO LIST YOU WITH THE CREDIT BUREAU SHOULD YOU NOT COMPLY WITH THE ABOVE TERMS.**

**By signing below, I acknowledge that I have read all the above conditions and hold myself bound thereto.**

**Signed:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_