



**Animal Allergy &
Dermatology Clinic**

James Jeffers, VMD, DACVD

9039 Gaither Rd ☐ Gaithersburg, MD 20877 ☐ email aadconline@gmail.com
☐ Phone (301) 977-9169 ☐ Fax (301) 977-7196

Client Registration

Date: _____

Client Name: _____

Address: _____

Email address: _____

Social Security Number: _____
(social security number is not required for cash or credit cards, only for check payments)

Co-owner or spouse name: _____

Pet Name: _____

Contact phone numbers (please place the primary number for us to contact you in the first line)

() _____ (home/ work/ cell)

() _____ (home/ work/ cell)

() _____ (home/ work/ cell)

Financial Responsibility Agreement:

I understand that payment is expected at the time services are rendered unless prior arrangements have been made. If an allergy vaccine is ordered for my pet, I understand that it is custom-made and cannot be used for any other Animal Allergy and Dermatology Clinic (AADC) patient. When I place an order for allergy vaccine with an AADC staff member, I understand I am financially responsible for the purchase of the product whether or not the product is used or ever picked up from AADC. I further understand that if any balance due AADC is not paid within 30 days of being incurred that I will be responsible not only for the balance due but also a \$15.00 monthly billing fee as well as for any collection and/or attorney fees spent in the attempt to collect this debt after 60 days of being incurred. I understand that a \$25.00 fee will be assessed for all returned checks.

Print name

Signature

Date