CLIENT CONSENT

Owners Name:_____ Pets Name:_____
Reason for todays visit:_____
_____

A phone number we can reach you at **TODAY:**_____

PLEASE LIST ANY MEDICATIONS YOUR PET IS CURRENTLY ON:_____
_____
_____

FOR THE PROTECTION OF YOUR PET AS WELL AS THE OTHER HOSPITAL GUESTS, YOU MAY INCUR AN ADDITIONAL FEE FOR TREATMENT IF YOUR PET IS FOUND TO HAVE EXTERNAL PARASITES INCLUDING BUT NOT LIMITED TO ticks, fleas, lice, mites, ect.

VACCINATIONS:

A thorough physical exam will be given prior to any vaccination. The fee for the exam is **$58.00** in addition to the vaccination price

☐ DHLPP/C…..…. $25.32 Canine
☐ BORDATELLA……. $20.88 Canine
☐ RABIES…… $21.30 Canine/Feline
☐ FELV……... $28.28 Feline
☐ RCPC……$16.00 Feline

OWNER INITIAL:_____

☐ I **decline** vaccinations at this time

CAC INITIAL:_____

CARDIOPULMINARY RESUSCITATION

Do you wish for CPR and other life saving measures to be taken if the situation arises? ☐YES ☐NO

OWNER INITIAL:_____

CAC INITIAL:_____

PRE-OPERATIVE BLOOD TESTING

Like you, our greatest concern is the wellbeing of your pet. An assessment of your pet's health will be done prior to anesthesia. However, many conditions including disorders of the liver, kidneys, or blood are not detected unless blood testing is performed.

If your pet is **under 5 years of age** and you would like to opt for Pre-Operative bloodwork, please check the box below

☐ I would like to have bloodwork done for my pet

Pre-Operative blood testing is **MANDATORY** on pets **5-8 years old** the additional cost will be **$86.75**

Geriatric blood testing is **MANDATORY** on pets **8 years or older**, the additional cost will be **$148.27**

OWNER INITIAL:_____

CAC INITIAL:_____

PLEASE READ AND SIGN THIS SIDE BEFORE FILLING OUT THE REST

Read and initial before processing with care

As the legal owner or agent, I give my consent for Companion Animal Clinic and its staff to administer medical and/or surgical treatment for my pet. I understand that unforeseen conditions may occur which could require additional of different treatments than initially expected
I acknowledge that there are risks of injury or death in the administration of anesthetics. I do not hold Companion Animal Clinic or its staff liable for the problems that might occur, provided reasonable care and precautions are followed.
I understand that additional charges may occur if I fail to pick up my pet at the agreed upon time. If a pet is left for more than fifteen (15) days, it will be considered abandoned.
As owner or agent, I assume financial responsibility for all charges incurred and recognize that the actual charges may be more or less than estimated, depending on the treatments rendered.

OWNER INITIAL_____

OUR PAYMENT POLICY

PAYMENT IS DUE AT TIME OF SERVICE: WE ACCEPT CASH, MC, VISA, DISCOVER, AND CARE CREDIT. IF YOU ARE EXPERIENCING FINANCIAL DIFFICULTY, PLEASE LET US KNOW AND WE WILL BE HAPPY TO RESCHEDULE YOUR APPOINTMENT FOR A MORE CONVENIENT TIME

SIGNATURE OF OWNER/AGENT
NAME:_____DATE:_____

DESCRIPTION OF ITEMS LEFT WITH YOUR PET

LEASH:_____COLLAR_____CARRIER_____
TOWEL/BLANKET_____OTHER_____