PATIENT DROP OFF

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:_____
_____
_____

VACCINATIONS:

A thorough physical exam will be given prior to any vaccination. The fee for the exam is **$60.00** in addition to the vaccination price

☐ DHLPP/C…..…. $25.00 Canine
☐ BORDATELLA……. $20.50 Canine
☐ RABIES…… $21.50 Canine/Feline
☐ FELV……... $28.50 Feline
☐ RCPC……$16.50 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:_____

SEDATION

I understand that some pets are scared and may not act like their normal selves when in a strange environment with unfamiliar people. For the safety of our staff and your pets, sedation might be necessary for some patients while they are in our care

☐ I consent to any sedation necessary for my pet
OWNER INITIAL:_____

☐ If my pet requires sedation please call me for consent
CAC INITIAL:_____

Please select ONE of the following options

☐ I accept the initial charges stated above, and agree to what we have already discussed, and I would like to me notified if the Doctor feels they need to do more

☐ I accept the initial charges stated above as well as any charges for necessary diagnostics, but request an estimate once diagnostics have been made for treatment associated with my pet's problem.

☐ I accept the initial charges stated above and do NOT request any further estimation of charges for my pet, giving Companion Animal Clinic the ability to diagnose and treat my pet as deemed necessary by the veterinarian. (This includes anesthetizing your pet if necessary)

PLEASE READ AND SIGN THIS SIDE BEFORE FILLING OUT THE REST

Read and initial before processing with care

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.

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_____
