AFTERHOURS
ETERINARY CARE
by Como Park Animal Hospital
1014 N. Dale Street St. Paul, MN 55117
Phone: 651-487-3255
Fax: 651-487-1941

Office Use

Date: _____

AVI #: _____

Rad # _____

☐ Calendar / Time: _____
☐ Entered in Avimark

Room: 1 2 3 4 5

Last Name: _____ **First Name**: _____

Additional Owners: _____

Street Address: _____ **City**: _____

State: _____ **Zip:** _____ **Primary Phone:** _____

Work/Cell Phone: _____ **Email**: _____

Pet's Name: _____ **Species (Circle): Dog Cat Bird Ferret Reptile Other**: _____

Breed: _____ **Color and Markings**: _____

Age/Date of birth: _____ **Sex (Circle): Male / Female / Unknown**
Unaltered / Spayed / Neutered / Unknown

➔**Regular Veterinary Clinic**: _____ **Name of Veterinarian**: _____

How did you hear about us: ☐ Referring Vet ☐ Friend: _____ ☐ CPAH Client: _____
☐ Drive by ☐ Internet Search: _____ ☐ Other: _____

Reason for visit/complaint: _____

AUTHORIZATION and CONSENT FOR SERVICES

The signer of this document has the authority to authorize surgery, diagnostics, treatments, and euthanasia for the pet(s) listed. I realize that I am financially responsible for decisions made by the above individuals on behalf of my pet and hold the doctors, staff, and agents of AfterHours Veterinary Care hospital harmless in the event that they make a decision that I may disagree with.

By signing below I agree that I am at least 18 years of age and assume full financial responsibility for the above mentioned pet(s).

_____ _____ $122.00

Signature of Owner **Date** **Exam Fee**

PAYMENT POLICY: Payment is expected at the time services are provided.
A deposit may be required for extensive medical or surgical procedures. The hospital accepts VISA, MasterCard, Discover, American Express, Checks, CareCredit and Cash. A **$30.00** service fee will be applied to all returned checks. Balances over thirty days will be subject to interest at the rate of 1.5% per month. I understand that if the balance is not paid in a timely fashion, I will be responsible not only for the balance due, but any collection agency fees, court costs, and/or attorney fees that are incurred in the attempt to collect this debt.

Office Use

BW: _____# _____kg T: _____ P: _____ R: _____ MM/CRT: _____

☐ **Completed by DVM** ☐ **rDVM** (Faxed) ☐ **CPAH** (Pink Slip) ☐ **No rDVM** ☐ **Docs Scanned** ☐ **Attached** ☐ **Follow-up**