Animal Hospital and Laser Surgery Center

Office Use

AVI #: _____

Patient #: _____

Entered By: _____

Welcome! And Thank You for Choosing Como Park Animal Hospital & Laser Surgery Center

CLIENT INFORMATION

The signer of this document and primary owner listed must be 18 years or older. Please include any co-owners. Minors and those not listed will not be allowed to make medical decisions. Information will not be shared with outside parties without your consent.

Owner's Name(s): _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:**_____

Cell Phone: _____ **Can we reach you by text message?** Yes / No

Email: _____

Were you Referred? _____ **By whom**?_____

PATIENT INFORMATION

Name: _____

Circle One: **Male / Female / Unsure** **Species:** _____

Intact / Spayed / Neutered **Breed:** _____

Age: _____ **Color(s) / Markings**: _____

Other pets in the house? Please list species: _____

Please list other past or current Veterinary Providers: _____

AUTHORIZATION and CONSENT FOR SERVICES

I, the signer of this document verify that all information contained in this document is correct and current. I will notify Como Park Animal Hospital of any changes to my contact or ownership information. I authorize that I am the owner of this patient, that I am at least 18 years of age and that I have the authority to authorize medical care for this pet - surgery, diagnostics, treatments, and euthanasia – to be performed by Como Park Animal Hospital, or AfterHours Veterinary Care on their behalf.

PAYMENT FOR ALL SERVICES IS DUE AT THE TIME SERVICES ARE PERFORMED.
I understand that I am financially responsible for all services rendered. A deposit may be required for certain medical or surgical procedures. The hospital accepts payment by Cash, Tele-Check, Visa, MasterCard, Discover, American Express, and CareCredit. 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.

By signing below I assume full legal and financial responsibility for the above listed pet.

Signature _____ **Date** _____

x_____ **Medical Records Release:** Please initial if you give us consent to release medical records for this patient. We will still ask for verbal authorization and a reason for transfer of records. This is for protection of your privacy and security of legal medical information. If you choose not to initial, we will require written consent at the time of records release.