Animal Care Hospital, P.C.
1146 Blairs Ferry Rd NE
Cedar Rapids, IA 52402
Standard Consent And Release

CLIENT #:
CLIENT NAME: Animal Care Hospital, 1
ADDRESS: 1146 Blairs Ferry Road N.E.
CITY/ST/ZIP: Cedar Rapids, IA 52402
PHONE: (319) 378-9000 EXT:
FIRST VISIT:

PATIENT #:
PATIENT NAME:
SPECIES:
BREED:
COLOR:
SEX:
BIRTHDATE:
AGE:

PLEASE READ AND UNDERSTAND ALL PROVISIONS BEFORE SIGNING THIS FORM.

I certify that I own or am an agent for the owner of the above described animal. **I do hereby consent and authorize Animal Care Hospital, P.C. to perform any diagnostic, therapeutic, anesthetic, emergency and surgical procedures deemed necessary by the Doctor for treating and maintaining my pet's health and well-being.**

I agree to allow my pet, if a dog, to be vaccinated against distemper, parvo and to have a heartworm test and fecal examination if the pet has not had any one of these in the last twelve months. I agree to allow my pet, if a cat, to be vaccinated against feline distemper, and to have a fecal examination if the pet has not had any one of these in the last twelve monthes. I agree to allow my pet, to be vaccinated against rabies if that vaccination is due according to hospital policy. If this pet is to be vaccinated against rabies or to be euthanized, then I attest that the pet has not bitten a person within the past 14 days. The above vaccinations and tests must be performed if I fail to provide acceptable written proof of vaccination. I agree to pay for all such services.

If we are performing dentistry on your pet and you request us to call you for permission to extract teeth this will increase the anesthesia time for your pet. We will not extract any teeth that do not need extraction due to gum disease, damage or cavities.

If my pet is found to have fleas or ticks upon entry to the hospital, I agree to allow Animal Care Hospital, P.C. to perform flea treatment and I will pay for this service.

I understand and agree that if my pet requires sedation or anesthesia that it may be required to spend the night in the hospital. I understand that for the health of all animals, all kennel and surgical areas are off limits to the public except by special permission and appointment. If my pet causes injury to a human or another animal, I will take full financial responsibility for that injury, and agree to hold Animal Care Hospital P.C. harmless and agree to indemnify Animal Care Hospital P.C against any damages sought against, or fees incurred by, Animal Care Hospital P.C., including attorney's fees, for that injury.

While I expect all procedures to be performed to the best of the staff's abilities, I realize that the hospital makes no guarantee or warranty regarding the results. In the absence of negligence, if my pet should injure itself, escape, fail to eat, become ill, or die, I will not hold Animal Care Hospital, P.C. or any staff member responsible.

I agree to make payment in full for all performed procedures and treatments at the time my pet is discharged. If I neglect to pay, my pet will become the possession of Animal Care Hosptial, P.C.. If I neglect to pick up my pet within five(5) days of written notice that it is ready for release and mailed to the above address, you may assume that my pet is abandoned. Upon abandonment, my pet becomes property of Animal Care Hospital, P.C. Abandonment does not release me of my obligation to pay my bill. I further agree that in the case of non payment, a finance charge of at least 1.98% per month plus a $3.50 statement processing fee will be charged and that any collection or attorney fees will be paid by me.

I have had the risks of the below stated procedures explained to me and I authorize Animal Care Hospital, P.C. to perform these services.

PROCEDURE(S):_____

_____

_____

_____

_____

TIME OF PICKUP:_____ **WHAT NUMBER CAN YOU BE CONTACTED AT TODAY:**_____

SIGNATURE OF CLIENT OR AUTHORIZED AGENT:_____

SIGNATURE FOR ANIMAL CARE HOSPITAL, P.C.:_____ DATE: _____