CASE #:________________ CLIENT #:_________________ PET:________________________

FAXED rDVM: _____________________ FAXED TLC Service: _____________________

For Office Use Only

CLIENT and PET INFORMATION

Please print legibly, fill out all sections, include phone area codes, & address zip codes

Financially Responsible Person/Owner:

(Dr.Mr.Mrs.Ms.)____

Circle One *Last* *First* *Middle*

Street Address: ____ Zip Code_________________

Mailing Address: ____ Zip Code_________________

Home Telephone: __________________ Work Telephone: __________________ Cell Phone:__________________

Employer:____

Employer's Address: ____

Email address: ____

Co-Owner/Spouse's Name OR Owner of Animal (if different from financially responsible person):

Name: ____

Street Address: ____ Zip Code_________________

Home Telephone: __________________ Work Telephone: _________________ Cell Phone:___________________

Employer: ____

Local Person to Contact in Case of Emergency: ____

Home Telephone: ______________________________ Work Telephone: __________________________________

AUTHORIZATION TO TREAT and FINANCIAL RESPONSIBILITY

I authorize Animal Emergency Critical Care, its Veterinarians and designated support personnel to examine and initiate life-saving emergency care and treatment for the pet presented. This may include, but not be limited to, treatment for shock and pain. I understand such treatment is necessary for the purpose of stabilizing the pet to enable a thorough evaluation and to ascertain a course of action.

I authorize the administration of emergency medical and/or surgical treatment deemed necessary on the basis of the doctor's findings and recommendations. If necessary, I consent to the administration of anesthesia. I understand no guarantee of successful treatment is made as there are advantages and potential complications with all procedures and treatments.

I assume financial responsibility for all charges incurred to this patient. If I am not the owner of the animal, I represent that I have been given authority by the owner to obtain medical and/or surgical treatment for this patient, and to incur charges for its care. **I understand payment, in full, is due at the time I pick up my animal, or at the time service is provided**. I understand AECC does not bill. Third-party financing is available and information can be provided to me upon request. Any outstanding balance will incur a late charge of 1.5% per month. AECC will also recover reasonable collection costs, attorney's fees and court costs incurred as a result of my failure to pay in accordance with this agreement. Any financial concerns should be discussed with the doctor prior to treatment in order to comprise a treatment plan in the best interest of the pet and pet's family. Medical information and contact information may need to be shared with TLC services and other veterinary hospitals in an effort to have a collaborative treatment plan. I consent to the release of information pertaining to this patient. I have read and fully understand this authorization for treatment and financial responsibility statement.

Signature of Owner/Responsible Agent: ____ **Date:** ____________

Name of Owner/Responsible Agent: ____

Signature of AECC Personnel: ___________________________ **Date and Time:** ___________________

PET'S INFORMATION

Pet's Name:_________________________________ **Breed:**________________________________

Color:_____________________________________ **DOB (Age):**_____________________________

Presenting Problem:____

Sex: Male ☐ Female ☐ **Is your pet spayed or neutered?** Yes ☐ No ☐

Species: Canine ☐ Feline ☐ Avian ☐ Rabbit ☐ Ferret ☐ Reptile ☐ Other_________________

Vaccination Status (Check if Current)

Canine / Dog: "Distemper" ☐ Parvo ☐ Rabies ☐ Lyme ☐ Bordetella ☐
Date of last vaccinations: ______________ **Is your dog on Heartworm Preventative?** Yes ☐ No ☐
If so, what type? ___________________________________

Feline / Cat: "Distemper" ☐ Rabies ☐ Feline Leukemia ☐ Date of last vaccinations: ____________
Is your cat on Heartworm Preventative? Yes ☐ No ☐ If so, what type? _____________________________

Ferret: "Distemper" ☐ Rabies ☐ Date of last vaccinations: ____________________________

Avian / Bird: Has your bird ever been tested or vaccinated for anything? Yes ☐ No ☐
If so, what? ___________________________________ When? ____________________________________

Known Medical Problems (e.g. allergies, seizures, diabetes) : ____
____
____

Current Medications: ____
____
____

Allergies to Medications:
____

Family Veterinary
HOSPITAL:____

Your Pet's Doctor: ____

HAS YOUR PET BEEN A PATIENT OF ANY OTHER TLC SERVICES? Please circle all appropriate ones:

Cardiology (CVCA) Dentistry (ADOS) Internal Medicine (LVIM) Neurology (BVNS)
Oncology (TOS) Ophthalmology (ECFA) PetsDx (MRI Imaging) Surgery (VSC)

HOW DID YOU HEAR ABOUT US? (Please circle one)

Referred by a veterinarian or hospital Yellow pages Community Phone Book
Hospital Sign Previous Visit Referral by a friend