Integrative Animal Hospital of Central Florida

255 Orange Blvd, Sanford, FL 32771 • www.IAHCF.com • 407.833.8868

Please Print:

How did you hear about us? _____

Owner's name: _____

PERSONAL INFORMATION

E-mail Address: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Spouse/Partner Name: _____

Spouse/Partner Cell Phone: _____ Work Phone: _____

Persons authorized to pick up my pet (ID required at pick up): _____

In case of an EMERGENCY whom (other than the above) should we call?

Name: _____ Cell Phone: _____

PET INFORMATION

Pet's Name: _____ DOB: _____ Sex: Breed: _____ Color: _____

Circle one: ☐Dog ☐Cat ☐Ferret ☐Avian ☐Reptile ☐Other Spayed or neutered? _____

Pet's Name: _____ DOB: _____ Sex: Breed: _____ Color: _____

Check one: ☐Dog ☐Cat ☐Ferret ☐Avian ☐Reptile ☐Other Spayed or neutered? _____

Pet's Name: _____ DOB: _____ Sex: Breed: _____ Color: _____

Check one: ☐Dog ☐Cat ☐Ferret ☐Avian ☐Reptile ☐Other Spayed or neutered? _____

Pet's Name: _____ DOB: _____ Sex: Breed: _____ Color: _____

Check one: ☐Dog ☐Cat ☐Ferret ☐Avian ☐Reptile ☐Other Spayed or neutered? _____

I hereby authorize the veterinarian to examine, prescribe or treat my pet(s). A written estimate of fees will be provided upon my request. I assume responsibility for all charges incurred in the care of my pet(s). I also understand that these charges will be paid at the time of release and that a deposit may be required for treatment and/or hospitalization.

ALL FEES ARE DUE AND PAYABLE AT TIME SERVICES ARE RENDERED

Signature of Owner _____ **Date** _____

CONSENT TO TREATMENT AND GUARANTEE OF PAYMENT

Consent to Treatment: I have been advised and understand that all services including vaccinations, medications, tests, surgical procedures, anesthetics, or treatments that are to be administered by Integrative Animal Hospital of Central Florida involve a risk of harm to my pet. After being advised of and understanding these risks, including death, I give my consent to Integrative Animal Hospital of Central Florida and its staff to provide these services. This agreement covers all staff members involved in my pet's care including the primary doctors on staff, and any relief vet covering for the clinics regular doctors. Further, I will ask to be advised of after care instructions for my pet and understand that these instructions must be followed for the health of my pet. I understand if I have additional questions or if a problem occurs, I should contact my veterinarian at this office immediately. If the veterinarian cannot be reached, and I deem it necessary to get immediate medical attention for my pet, I understand I should go to the nearest emergency veterinary clinic and follow up with my regular veterinarian at this office as soon as possible afterwards. I understand the clinical and administrative staff may review my pet's records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

Patient/Guarantor Agreement: I understand, that if my pet needs emergency care, the doctors will use any and all treatment options at their disposal. This includes medications, surgery, and any alternative therapies available, such as; radio frequency therapy and/or hypothermia. I understand that I must pay for services provided to my pet based on the hospital payment policy. I understand that the clinic is not in the business of extending credit and therefore, requires payment in full at the time services are rendered. I agree that my appointment may be rescheduled if I cannot provide payment for services that will be rendered today or if I have an outstanding balance from a previous visit. I understand that I may be sent to collections if I fail to resolve any outstanding balance. I agree to provide my driver's license for identification purposes. Integrative Animal Hospital of Central Florida uses Tele-check services to verify all checks. I understand that any returned check is subject to a $30 service fee.

Client Statement: All of my questions and concerns will be addressed and answered to my satisfaction. I will receive instructions by printed literature or verbal explanation at my request concerning my pet's aftercare. I understand that further information is available upon my request regarding my pet's care should the need arise. Furthermore, I agree that it is my responsibility to call the office to obtain the results of my pet's lab work. I agree to keep my veterinarian's office informed of any changes in my pet's condition or physical health.

Concerning Vaccinations: I understand that some pets have adverse reactions to vaccines. Integrative Animal Hospital of Central Florida is not responsible for my pet's vaccine reaction should this circumstance arise. I understand that I am financially responsible for any additional fees incurred to treat my pet for any vaccine reaction. I understand that the current vaccine protocol is such that distemper is given every three years or as otherwise requested by the pet owner.

*By voluntarily signing below, I agree that I have read, or have had read to me, this consent form. I understand and agree to all terms outlined herein. I have had an opportunity to ask questions. I intend this consent form to cover the entire course of my pet's healthcare for present or future condition(s).

_____ _____

Client's Full Name (Signature) **Date**

_____

Client's Full Name (Print)