COLONIAL ANIMAL HOSPITAL

DROP OFF/HOSPITALIZATION CONSENT FORM

Client's Name: **Pet's Name:**

	Yes	No	Date Started
Vomiting / # times			
Diarrhea			
Coughing			
Sneezing			
Loss of Appetite			
Straining to Urinate			
Blood In Urine			
Lethargy			
Increased Thirst			
Increased Urine			

Other Signs: ____

Has your pet ever had this before? _______ If yes, then what was the diagnosis and therapy:

Does the doctor have permission to run Diagnostic Tests ______X-rays ______?

Does the doctor have permission to initiate treatment before talking to you? ______

CONSENT FOR ADMISSION TO HOSPITAL

I am the owner or agent for the owner of the animal(s) described on this form and have the authority to execute this consent.

I request that the veterinarians, agents and employees of Colonial Animal Hospital perform the services which are necessary to the examination, medication and treatment of the animals specifically described and identified on this form.

I authorize the veterinarians on duty (and the assistants they designate) to examine the animal(s) and to administer medical treatment or emergency surgical treatment which is considered therapeutically and/or diagnostically necessary on the basis of the findings during the course of the examination. Therefore, I hereby consent to and authorize the performance of such procedure(s) as are necessary and desirable in the exercise of the veterinarian's professional judgment.

I further understand that any animal found to be infected with either external or internal parasites will be treated for same at my expense.

I understand that the treatment of the patient will be conducted with due care and in accordance with the prevailing standards of competency in Veterinary Medicine. I certify that no guarantee or assurance has been made as to the results that may be obtained through the course of treatment undertaken by the veterinarians, agent or employees of Colonial Animal Hospital.

I assume financial responsibility for all charges incurred to the patient for services rendered and understand that full payment is required upon discharge. In case of non-payment, I am aware that Colonial Animal Hospital will charge the cost of collecting the debt on the amount owed for services. This includes the collections company's charges, attorney's fees and interest of 1.5 % per month (18% annum).

I understand that a written estimate of charges is available within reasonable time at my request. I also consent to the release of medical information.

Signature:_____________________________________ **Date:**__________

Daytime contact phone: _______________________

Home phone: _________________________