Emergency Intake Form

Owner Name: _____ Owner Phone: _____

Owner Address: _____ City: _____ Zip: _____

Alternate Owner: _____ Alternate Phone: _____

Pet's Name: _____ □ Canine □ Feline □ Other _____

Breed: _____ Sex: _____ Spayed/neutered: □ Y □ N

Age/DOB: _____ Color/markings: _____

Veterinary hospital pet attends: _____

When was your pet last vaccinated for Distemper and Rabies? _____

List any medications your pet is on: _____

List any chronic illnesses or allergies your pet has: _____

Please describe why your pet is here today:

_____

- ## Treatment Authorization and Information

I hereby authorize Ark Veterinary Hospital & Urgent Care to perform medical and diagnostic/surgical procedures on my pet as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants. If I have been referred to this hospital by another veterinarian, I understand that they will receive a summary of the care and treatment provided in a timely fashion. I also understand that by my identifying a referring veterinarian I am authorizing Ark Veterinary Hospital & Urgent Care to release records and information to that veterinarian. In the event this animal transfers ownership, I authorize release of medical information to the new owner, should they request it. I also understand that with emergencies comes additional risk for diagnosis, treatment, and anesthetic and surgical procedures. I have had those risks satisfactorily explained to me and I agree not to hold Ark Veterinary Hospital & Urgent Care, the veterinarian(s) or staff liable for injury, illness or death of my pet.

- ## Financial Policy

Payment is due as services are rendered unless prior arrangements are made. For hospitalized cases, a 75% deposit is required in advance. The balance is due upon discharge from the hospital. You may pay by cash, credit card, or Care Credit. In the event payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 30 days old. An additional service fee of $3.00, and 1.5 % of the outstanding balance will be charged to your account monthly if not paid in full. Balances over 60 days will be forwarded to a collection agency and you will be charged collection and attorney fees as the law allows.

- ## Authorization

I understand that I (the owner or agent) am financially responsible to Ark Veterinary Hospital & Urgent Care for all charges relating to this patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

Owner/Agent Signature: _____ Date: _____