MEDICAL TREATMENT CONSENT FORM

CLIENT INFORMATION:

First Name: _____ Last Name: _____

Best contact number: _____

Please list those whom are authorized to pick up your dog:

1.) Name: _____ Relationship: _____

CURRENT MEDICAL CONCERN

Patient: _____

Primary Complaint(s). List all that apply:

_____

_____

Have any medications been given today? □ Yes □No If yes, what was given?

_____

Would you like any additional services completed today (i.e. vaccines, bath, nail trim, etc.)?

_____

Do you need an estimate today? □ Yes □No

*****For anticipated services, please refer to the estimate that has been given to you. If additional services are needed, we will contact you to discuss your pet's condition and any necessary treatments and/or procedures that*****

TREATMENT/FINANCIAL AUTHORIZATION

I hereby authorize Kennesaw Mountain Veterinarian Services to perform medical and initial diagnostic/surgical procedures on my pet as required for diagnosis and/or treatment based on the estimate I received (see above. Client has the option to accept or decline an estimate). Our medical staff will contact you if any additional treatments/procedures are necessary beyond the initial treatment plan.

Every reasonable precaution will be used against injury, escape or death of any pet. The clinic and staff will not be held liable for problems that develop with pet provided reasonable and precautions be followed. I understand that any problems that develop with my pet will be treated as deemed best by the staff veterinarians and I assume full responsibility for the treatment expense involved. Payment is due as services are rendered. For hospitalized/admitted cases, a deposit MAY be required in advance. The balance is due upon discharge from the hospital. Payments can be made by cash, personal check (deposited electronically prior to patient discharge with proper identification), and accepted credit cards, including Care Credit. If payment arrangements are needed, the undersigned realizes that they must be agreed upon prior to admitting patients. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory. I have read and accept the preceding obligations.

OWNER(S) SIGNATURE:_____ DATE: _____