

FORT WORTH VETERINARY SURGICAL

OWNER & PATIENT INFORMATION

Owner Name: _____ Date: _____

Address: _____ City: _____ State _____ Zip _____

email address _____

Home phone: () _____ cell: () _____ wk: () _____

Referring Veterinarian: _____ Phone: () _____

Patient name: _____ Sex: _____ Date of Birth _____

Breed: _____ Is Patient insured: _____ yes _____ no

FINANCIAL & PAYMENT POLICY

Thank you for the opportunity to help you meet your pet's surgical needs. As discussed, the estimated fee for medical and surgical care is \$_____. Once treatment has begun, changes in the healthcare plan may be required depending upon results of diagnostics or changes in your pet's condition. We will contact you if the cost of care is expected to exceed the amount listed above and discuss further treatment options.

_____ (owner initials)

Lab work: Accepted Declined Provided

FULL PAYMENT IS DUE BEFORE SURGERY. Please circle your payment choice:

Credit Card

Care Credit Payment Plan

Cashiers Ck/MO

All charges are due before treatment. In case of non payment, a finance charge of 1.5 percent per month (18%) per annum will be assessed from the date of discharge.

ADDITIONAL POLICY INFORMATION: A fee of \$50 is charged for clients who miss or cancel more than 2 appointments in a calendar year without 48 hours notice. We will be happy to provide you with the necessary documentation to submit an insurance claim.

By signing below, you agree to the terms of payment:

Signature or Owner or Agent

Date

TREATMENT CONSENT

I am the owner or agent of the described patient on the preceding page and have the authority to execute this consent. I hereby consent to the following procedures:

I understand that during the performance of the foregoing procedure or operations, unforeseen conditions may be revealed that necessitate an extension of the foregoing procedures or operations of different procedures or operations than those set forth above. Therefore, I hereby consent to and authorize the performance of such as are necessary and desirable in the exercise of Dr. Dean's professional judgment.

I also authorize the use of appropriate anesthetics, and other medications and I understand that hospital support personnel will be employed as deemed necessary in the exercise of Dr. Dean's professional judgment.

I agree that Dr. Dean and Fort Worth Veterinary Surgical staff will not be held responsible in any way for accidents that occur during hauling, loading or unloading of my animal.

I realize that results cannot be guaranteed.

I further understand that as beneficiary that all insurance claim forms will be withheld until payment is made in full.

I have read and understand this service contract, release agreement and authorization.

Signature of Owner or Agent

Date