Drop Off Exam Agreement

Date: ____________

Pet Owner:____

Address:____

City/State:________________________ZIP:______________________

Home Phone:_____________________ Work Phone:_____________________

Pet's Name:____

Species:_________________ Breed:________________ Color:______________

Age:________ Sex:_______________ Weight:____________

My animal is:

Vomiting	**Diarrhea**	**Coughing**	**Sneezing**
Yes	Yes	Yes	Yes
No	No	No	No
Loss of Appetite	**Straining to Urinate**	**Blood In Urine**	**Lethargy**
Yes	Yes	Yes	Yes
No	No	No	No
Increased Thirst	**Increased Urine**	**Limping**	
Yes	Yes	Yes	
No	No	No	

Additional Issues:

____

____

Other signs

Has your pet ever had this before?

Yes
No

Does the doctor have permission to run

Diagnostic Tests Yes No
X-rays or Ultrasound Yes No

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

Yes
No

Owner or Agent Signature **Date**

______________________________________ _______________

Drop Off Exam Agreement

Owner Name ______________________________________

Pet Name ____

Phone Number ____________________________________

I am the owner or agent for the owner of the animal described on this form and have the authority to execute this consent.
I request that the veterinarians, agents and employees of Elm Grove 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 agree to be available by phone at all time when my animal is at Elm Grove Animal Hospital.

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 the 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 Elm Grove 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 Elm Grove 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 if a written or verbal estimate of charges is given that it is an estimate at the time at my request and that the amount may change. I consent to the release of medical information.

____ I understand that the doctor is here only one day a week.

____ I understand that Elm Grove Animal Hospital is not an emergency hospital.

____ I understand that if Elm Grove Animal is unable to treat my animal that I am responsible to find an emergency veterinary hospital.

____ I agree to contact an emergency vet facility if there are any problems when the doctor is not at the facility.

After carefully reading the above, I have signed an agreement.

______________________________ ______________________

Owner or Responsible Party Date

Elm Grove Animal Hospital 146 Clifton Heights Rd Wheeling WV 26003 Phone: (304)242-6720 Fax: (304)242-6721 Email: elmgroveanimalhospital@gmail.com