VRCC
VETERINARY SPECIALTY & EMERGENCY HOSPITAL

HOSPITAL USE ONLY	
	Wt:
	Room#:
	Time:

Patient Intake Form

Client Information

First Name:	**Last Name:**	**M.I.:**	**Soc. Sec. #:**
Additional Authorized Guardians:			
Mailing Address:			
City:		**State:**	**ZIP:**
Home Phone:	**Work Phone:**		**Cell Phone:**
E-mail:			
How did you hear about us? *(check all that apply)*	☐ Website/Internet/Facebook ☐ Radio/TV ☐ Magazine/Newspaper ☐ Local Event ☐ Walk In ☐ Family/Friend ☐ Family Veterinarian ☐ Previous visit to VRCC ☐ Other		
Family Veterinarian/Hospital:			

Patient Information

Pet's Name:	**Species:** ☐ Canine ☐ Feline ☐ Other	**Color:**
Breed:	☐ Male ☐ Female ☐ Male Neutered ☐ Female Spayed	**Birthdate or Age:**
Initial Presenting Problem:		

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize VRCC practices to perform medical and initial 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 or assistants.

If I have been referred to this hospital by another veterinarian, I understand that they will require a summary of the care and treatment provided by the VRCC practices in order to ensure that my pet's care can be continued without interruption. I also understand that VRCC considers the identification of a referring veterinarian by me to be my authorization to release records and information to that veterinarian.

VRCC is a leader and teaches in the veterinary medical field, thus case information and/or photos may be used in teaching, forms, continuing education, web site, veterinary literature, etc.. I authorize the release of case/patient information for such purposes. Patient confidentiality (names withheld) will be maintained.

In the event I transfer ownership, etc. to another party, I authorize release of medical information to the new owner, should they request it.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance.The balance is due upon discharge from the hospital. Payment may be by cash, personal check (with proper identification), or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

A service fee of $3.00 and 1.5% of the outstanding balance will be charged to your account monthly if not paid in full. If applicable, you will be responsible for any lawyer and/or collection agency expenses that may be incurred.

Returned checks are subject to penalties under the Colorado Returned Check Law, C.R.S. 13-21-109. For additional information on the Colorado Returned Check Law, see www.ago.state.co.us/CADC/BadCheckLaw.cfm or call the Office of the Colorado Attorney General at 303-886-5304.

I understand that I, as the owner or agent am financially responsible to the applicable VRCC practice(s) for all charges relating to this patient. I have read and agreed to the treatment authorization. I have also read and accepted the financial obligations.

Signature: _____ Date: _____