General Consent Form

(Rechecks, Phase II, Yearly Vaccines, Etc.)

Date: ________/________/________
Owner Name: __________________________________
Patient Name: ______________________
Species: ___________________________ Breed: _______________________
Sex: _______________
Phone number that you can be reached at today: ____
Service(s) to be performed: ____
____
____

Please Read Carefully and Sign:

I, the undersigned owner, or authorized agent of the pet identified, authorized the veterinarian(s) and staff at Angelina Animal Hospital to perform the above procedure(s). I understand that some risks are always exist and that I am encouraged to discuss and concerns that I have about the risks with the attending veterinarian before the procedure(s) is/are initiated. My signature on this form indicates that any questions that I may have regarding the following issues have been answered to my satisfaction.

- Sufficient details of the procedures to understand what will be performed
- How Fully my pet will recover and how long it will take
- The most common and most serious complications
- The length and type of follow-up care required
- The estimate of the fees for all services provided
- **May muzzle if needed**

Before performing the above agreed upon services, your pet must be up to date (minimum of Rabies) and free of any external parasites, i.e. fleas and ticks. We also highly recommend testing for heartworms and intestinal parasites. If your pet is not current on the above, *additional charges* may be incurred to have these completed and cleared by our hospital. *Each animal at AAH is required to be flea free, AAH staff will administer a Capstar at owners' expense if fleas are seen while being treated.*

Deposit for today's services $________________ initial___________
Estimate for today's services$________________ initial___________

Veterinarian who administered Rabies Vaccine: Dr.______________________________ May we contact? Y/ N
Date Administered: ____/____/____ EXP: ___/___/____ Phone:(____)-_____-_________

While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no guarantee or warranty has been made regarding the results that may be achieved. I agree to assume fiscal responsibility and provide payment via cash, check, or credit card. I have read and fully understand the terms and conditions set forth above.

Signature of Owner
or Authorized Agent: _________________________________ Date: ______/______/_______