

San Gabriel Animal Hospital Hospital Admission Form

Patient _____

Pet Owner _____

Date of Admission _____

Estimated Duration of Hospitalization _____ days

Staff Initials _____

Deposit (50% of total estimate) \$ _____

PAYMENT IN FULL IS REQUIRED AT DISCHARGE

VACCINATIONS: To insure the protection of all pets in our care we require your pet to be up to date on vaccines. (Proof is required from other veterinary clinics). All pets with external parasites must also be treated prior to admission to our facility.

CALLING HOURS: A report on your pet's medical progress will be available after morning medical rounds. Call between 10 a.m. and 12 noon or between 3p.m and 4p.m. The doctor will be treating other patients or performing surgery throughout the day. Please have only one member of the family call each day. If unavailable when you call, the doctor will return your call as soon as possible.

FEES: Communication between the hospital and pet owner concerning fees is essential to the best possible veterinary medical care. Prior to admission, a deposit of 50% total estimated cost is necessary for the initiation of any treatment. Please do not hesitate to discuss your pet's treatment program and it's cost with the receptionist.

PAYMENT: Payment is required when treatment is performed and before your pet may be discharged. The final cost for medical or surgical care is determined by your pet's disease/condition and your pet's response to treatment.

INITIAL ESTIMATE

Professional Evaluation _____

Immunizations _____

Fecal _____

Heartworm Test _____

Initial Laboratory Fees _____

Radiology (Pre & Post) _____

Cast/Bandages _____

Fluids SQ IV _____

Hospitalization @ _____ /day _____

Nursing Care @ _____ /day _____

Estimated Days _____

Pharmacy (Inpatient) _____

Pharmacy (Outpatient) _____

Other _____

Minimum Estimate _____

AUTHORIZATION FOR MEDICAL OR SURGICAL CARE

I authorize and direct the doctor(s) and staff of the above named veterinary medical hospital to perform such diagnostic or treatment procedures as my be advisable and necessary for the health of my pet. The nature of these procedures has been explained to me and no guarantee had been implied or made as to the results or cure. I understand that there may be risk involved in the treatment of my pet.

I agree to pay, in full, for all services rendered for and to my pet, including those deemed necessary for medical or surgical complications due to unforeseen circumstances. The above estimate is an approximation and the final bill may be greater or less than this amount.

ALL SERVICES ARE STRICTLY CASH (NO BILLING) AND MUST BE PAID AT THE TIME OF DISCHARGE.

Payment will be made by:

CASH CHECK M/C VISA AMEX DISC DEBIT

I have read the above conditions for the care of my pet and acknowledge receipt of a copy of this form.

Owner/Agent _____

Date _____ / _____ / _____

I can best be contacted at home (____) _____ - _____

Work (____) _____ - _____

Cell (____) _____ - _____