

Room # _____

Valley Central Veterinary Referral and Emergency Center

Consent and Medical/Surgical Care Plan

PATIENT NAME: _____ OWNER NAME: _____

IM ESTIMATE \$ _____ SURGICAL ESTIMATE \$ _____ ER ESTIMATE \$ _____

TREATMENT PLAN: _____ U/S Fee \$ _____ Yes No

Consent for CPR or DNR:

In the case that your pet was to suffer cardiac and/or pulmonary arrest (heart or breathing stops), do you authorize us to provide life-saving measures (i.e. cardiopulmonary resuscitation)? COSTS OF THESE SERVICES CAN BE BETWEEN \$200.00-\$500.00 AND ARE NOT REFLECTED IN THIS ESTIMATE. If you choose to allow these procedures for your pet, you will be contacted as soon as possible to be informed of the situation and given the options how to proceed.

_____ CPR I authorize appropriate life saving measures. I understand that the cost of services may exceed this estimate and I will be billed for any and all such costs.

I do not wish for life saving measures to be employed. I am electing "Do Not Resuscitate" status for my pet. _____ DNR

By initialing on the lines below you are acknowledging your understanding and agreement to each statement:

_____ If being seen on an emergency basis we require that you pay the exam fee of \$145 up front in the form of a deposit. Once your pet has been examined, the doctor will consult with you regarding a recommended treatment plan. An estimate of this treatment plan will be explained to you, and a full deposit equal to the high end of the estimate will be required at this time.

_____ As our name implies we are a Specialty and Emergency Center, and as such, we regret that we cannot offer a payment plan or any type of billing. It is our policy that we require payment in full at the time of service. A \$35.00 service fee will be applied for all returned checks. Unpaid balances are subject to attorney and legal fees as appropriate. The health and well-being of your pet remains our top priority, however, rising losses due to non-payment for services rendered have forced us to adhere to this strict financial policy.

_____ Re-evaluations that may be required in the future are not covered in this estimate unless stated otherwise. Patients seen by our specialty department(s) seen after hours by our emergency department will incur additional charges.

THIS FORM REPRESENTS AN ESTIMATE OF THE COSTS FOR YOUR PET'S HEALTH TREATMENT PLAN AS RECOMMENDED BY THE VETERINARIAN. THIS IS NOT A QUOTE OF ACTUAL CHARGES, BUT RATHER A GOOD FAITH ATTEMPT TO PREDICT THE TOTAL CHARGES. THE ACTUAL AND FINAL BILL MAY BE LOWER OR HIGHER THAN THIS ESTIMATE. AS WITH ANY HEALTH TREATMENT PLAN, IF YOUR PET'S CONDITION CHANGES, SO MAY THE RECOMMENDED TREATMENT PLAN. WE WILL MAKE EVERY ATTEMPT TO INFORM YOU AS WE APPROACH THE UPPER LIMIT OF THE ESTIMATE OR EXCEED IT. AT THAT POINT WE WILL REQUEST AN ADDITIONAL DEPOSIT. PLEASE DO NOT HESITATE TO ASK FOR AN ESTIMATE UPDATE AT ANY TIME DURING YOUR PET'S HOSPITALIZATION. ADDITIONALLY, IF YOUR PET IS TRANSFERRED FROM THE EMERGENCY DEPARTMENT TO OTHER SPECIALTY DEPARTMENTS, OR REQUIRES ANY ADDITIONAL TREATMENT, THERE WILL BE ADDITIONAL COSTS AND FEES ASSOCIATED WITH ANY SUCH TREATMENT AND YOU AGREE TO PAY THE COSTS OF ANY SUCH ADDITIONAL FEES. THIS DOCUMENT DOES NOT INCLUDE THE ESTIMATE FOR ANY SUCH ADDITIONAL TREATMENT.

_____ General anesthesia carries an inherent a risk to the patient which has been explained and is understood.

_____ A deposit equal to the full estimate is required for specialty care at the time of admittance.

_____ Indications, success rate, and possible complications of the procedure have been explained.

PLEASE READ CAREFULLY, by signing below you are agreeing to the following: I, the undersigned, certify that I am the owner or authorized agent for the pet described above and have the authority to execute this consent. I am over 18 years of age. I acknowledge that I have read and understand VCVREC payment policy and agree with it, and consent to have the veterinarian and staff of VCVREC examine my pet and perform any medical, surgical and/or emergency treatment, and agree to be responsible for all charges related to my pet's care. I have also read the anesthesia and life support policy and agree. I have had the opportunity to ask any questions that I may have regarding the above policies that were given. I certify that all the information I have provided above is true and to the best of my knowledge. This Agreement shall be governed by, construed and enforced in accordance with the laws of the Commonwealth of Pennsylvania. I recognize and accept that the Court of Common Pleas of Lehigh County, Pennsylvania shall have exclusive jurisdiction and venue for any disputes under this Agreement.

TELEPHONE CONSUMER PROTECTION ACT (TCPA): You agree, in order for us to service your account or to collect monies you may owe, VCVREC, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/ artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that VCVREC, its employees and/or agents may contact me/us as described above.

OWNER / AGENT: _____ DATE: _____

PREFERRED PHONE NO: _____ SECONDARY PHONE NO: _____

Below For Office Use Only

Deposit \$ _____ Staff Initials _____ 2ND Deposit \$ _____ Staff Initials _____ Addt'l Deposit \$ _____ Staff Initials _____

Imprint Yes _____ No _____ Staff Initials _____

Verbal Updated Estimate Given To Owners \$ _____ Date: _____ Staff Initials _____

Verbal Updated Estimate Given To Owners \$ _____ Date: _____ Staff Initials _____