

Animal Hospital of Pasco

3012 N Road 92
Pasco, WA 99301

(509) 545-9949
www.pascovets.com

Drop-Off Form

Form P-508
Rev. 01/15/2019

"Drop-off" appointments give owners and doctors some much needed scheduling flexibility, allowing a patient to be seen when a regular appointment isn't feasible. Ideally, the patient is dropped off between 8:00 and 10:00 AM. Although we will do our best to have your pet ready before closing, it is possible that pets dropped off after 10:00 AM, or those requiring hospitalization, may need to stay overnight. We will call you at the number(s) you provide on this form to let you know when your pet will be ready for discharge.

Client/Authorized Agent Information

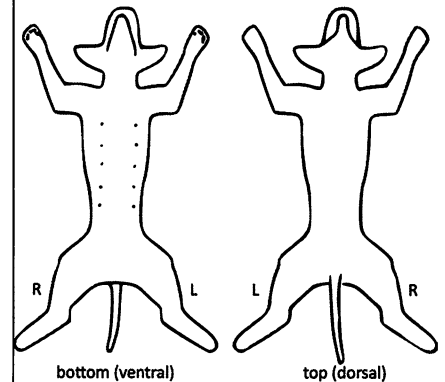
| | | | |
|--|------------------|--------------------------------------|--|
| Your first name | Your middle name | Your last name | Suffix (Jr., III, etc.) |
| Current home address: <i>(include city, state, ZIP; no P.O. boxes please)</i> | | Phone number(s) we can reach you at: | Are you the owner of this pet? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are <u>not</u> the owner, what is the owner's first and last name? |
| | | | If you are <u>not</u> the owner, has the owner completed the form necessary to designate you their authorized agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked 'No' above, please be aware that you will be responsible for payment in full when the patient is discharged. |

Patient Information

| | | | |
|--|--|--|------------|
| Patient's name | Patient's date of birth or age as of today | Species <input type="checkbox"/> dog <input type="checkbox"/> cat | Color/coat |
| Patient's sex <input type="checkbox"/> intact male <input type="checkbox"/> neutered male <input type="checkbox"/> intact female <input type="checkbox"/> spayed female | | Please list any allergies or medical conditions the doctor should be aware of. | |
| Is your pet on any medications? If so, when was the last dose given? | | | |

In the box below, please tell us why we're seeing your pet today. **Be specific.** If your pet is ill or injured, please describe the symptoms in detail and indicate any relevant locations on the diagram below. (For example, if your pet is lame, circle or color in the hurt leg.) Be sure to state **when** the impairment occurred or began to the best of your knowledge. If you would like any ancillary services (e.g. nail trim, anal gland expression) please note those as well.

- lethargic
- not eating
- not drinking
- vomiting
- coughing/sneezing
- labored breathing
- nasal discharge
- increased urination
- not urinating
- diarrhea
- constipation
- itchy skin
- rash/redness
- swelling
- unusual odor
- dizzy/disoriented
- convulsing
- painful



If your pet is ill or injured, an exam will be performed. After the exam, if any testing or procedures are needed for the diagnosis/treatment of your pet, we should:

- Perform necessary test(s) and/or procedure(s) as long as they remain below a \$_____ limit.*
- Do all that is necessary to maintain the well-being of your pet.

* If this limit impedes adequate care, we will attempt to contact you at the phone number(s) you've provided above. If we cannot reach you, decisions about how to proceed may be left to the discretion of the attending veterinarian.

The nature of such service has been described to me to my satisfaction and I realize that no guarantee nor warranty can ethically or professionally be made regarding the results or cure. I understand that I assume financial responsibility for all services rendered, and that payment is due at time of patient discharge. I certify that I am at least 18 years of age and that I am the owner of, or authorized agent for, the patient described above. In consideration of Animal Hospital of Pasco, P.S. accepting my pet for treatment/diagnostic testing, I do hereby release, discharge, and waive any claims, demands, and/or actions against Animal Hospital of Pasco, P.S., its agents, employees, officers, and insurers arising from or relating to injury, illness, or death that may occur during the period of hospitalization. I understand that a finance charge is applied to all accounts unpaid after 30 days. This finance charge is computed by a periodic rate of 1.5% per month which is the annual percentage rate of 18.00%; minimum monthly charge is \$1.50.

Signature of Owner or Authorized Agent

Date

IMPORTANT: SIGNATURE MUST BE IN INK AND CANNOT BE TYPED. PLEASE SIGN AND DATE ON THE DAY OF SERVICE.