Darryl L. D. Brown, DVM
404.867.4081 Mobile

Healing Hands MOBILE VETERINARY SERVICE

Authorization for Treatment

I hereby authorize Healing Hands Mobile Veterinary Service, hereinafter known as HHMV, LLC, its employees or agents to receive, hospitalize, care for, vaccinate, prescribe for, medicate, test, bathe, sedate, anesthetize and / or operate upon my animal as deemed necessary for the health, saftety and well-being of my pet.

Thank you for giving us the opportunity to care for your pet. So that we may become better acquainted, please complete the following:

OWNER: _____ DATE: _____

ADDRESS: _____
Street City Zip

PET'S NAME: _____

Phone: _____ Email: _____

PROCEDURE TO BE PERFORMED TODAY: _____

_____Cash _____Check _____Visa/Master Card

Are vaccinations and laboratory tests current today? ☐ YES ☐ NO (Within the last year) ☐ YES ☐ NO

DOGS			CATS		
YES	NO	UPDATE TODAY	YES	NO	UPDATE TODAY
☐	☐ Rabies	☐	☐	☐ Rabies	☐
☐	☐ DHLP/Parvo	☐	☐	☐ FVRCP	☐
☐	☐ Bordetella	☐	☐	☐ Feline Leukemia	☐
☐	☐ Heartworm Test	☐	☐	☐ Intestinal Parasites	☐
☐	☐ Intestinal Parasites	☐			

YES	NO	
☐	☐	Did your pet eat this morning?
☐	☐	Is your pet allergic to any drugs?
☐	☐	Has your pet had any illness or injury in the past 30 days?
☐	☐	Does your pet have any history of seizures and/or previous anesthetic problems?
☐	☐	Current medications _____

***PRE-SURGICAL BLOOD SCREEN CONSENT/WAIVER**

Like you, our greatest concern is the well-being of your pet. A physical examination will be performed before anesthetizing your pet. However, many conditions, including disorders of the kidneys, liver, heart & blood cannot be detected without blood lab screening. For this reason, we highly recommend pre-operative screening before sedating your pet. Please initial the appropriate options below: (pre-surgical blood screen required on all pets seven years of age or older).

☐ I DO ☐ I DO NOT authorize the recommended pre-surgical blood screen at a cost of $_____. I understand and assume all responsibility for additional risks/complications resulting from refusal to approve this blood screening for my pet's safety.

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ELECTIVE PROCEDURE TO BE DONE AT THE SAME TIME: *(Please check applicable boxes)*

- ☐ Dismissal Pain Medication
- ☐ Dental procedures: ☐ Extract Teeth as Necessary
  ☐ Scale/Clean Teeth/Fluoride Application
- ☐ Heska Periodontal Treatment
- ☐ Microchip Identification
- ☐ Removal of wart or skin growth
- ☐ Routine Toe Nail Trim
- ☐ Ear Flushing
- ☐ Other _____

BLOODWORK: *I have been informed that blood chemistry analysis to evaluate the function of internal organs (Kidney, Liver, Pancreas, etc) prior to anesthesia is advisable for pets under six (6) years of age and mandatory for those over six years.* ☐ *I request bloodwork $_____* ☐ *I refuse bloodwork*

INTRAVENOUS CATHETER: *I also understand the pre-operative intravenous catheter placement, allowing for Rapid Medical Response in case of an unexpected intra-operative drop in blood pressure is advisable* ☐ *I request intravenous catheter $_____* ☐ *I refuse intravenous catheter*

ANALGESIC: *A long acting injection to alleviate pain / discomfort is available at my request.* ☐ *I request analgesic $_____* ☐ *I refuse analgesic*

PROCTECTIVE ELIZABETHAN COLLAR: *A collar is offered to proctect sutures from chewing* ☐ *I request E. Collar$_____* ☐ *I refuse E. Collar*

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize HHMV 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 and assistants.

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

FINANCIAL POLICY

I assume full financial responsibility for all expenses incurred in the treatment of my pet and authorize my pet's immunizations to be brought current. Vaccinations that are over 11 1/2 mo. (due within 2 wks) must be brought current on this visit.

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge. You may pay 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.

In the event payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 30 days old. 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. **All returned checks will incur a charge of $35.00**

I understand that I (the owner or agent) am financially responsible to the applicable HHMV practice(s) for all charges relating to this patient.
I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

Signature:	Date: