PAW HEALTH NETWORK, INC.

PATIENT CHECK-IN FORM

Have you/your spouse been here before? ☐ Yes ☐ No

Has this patient been here before? ☐ Yes ☐ No

CAREGIVER INFORMATION

You are the... ☐ Owning Caregiver ☐ Acting Agent

Last Name ____________________ Primary Phone ____________________

First Name ____________________ Secondary Phone ____________________

Spouse ____________________ Work Phone ____________________

Address ____________________ Email ____________________

City ____________ State ________ County ____________ Zip ____________

Primary Care Veterinarian ______________________________

PATIENT INFORMATION

Species ☐ Canine ☐ Feline ☐ ____________

Gender ☐ Male ☐ Female

Status ☐ Intact ☐ Spayed/Neutered

Name ____________________ Coat Color ____________________

Breed ____________________ Age/Birth Date ____________________

MEDICAL INFORMATION

Short Description of Presenting Problem ______________________________

Major Surgeries / Medical Diagnoses ______________________________

List Flea/Tick/Heartworm Prevention ______________________________

Food Brand & Type ______________________________

Known Medication Allergies ______________________________

Current Medications ______________________________

Last Vet Visit & Vaccination(s) ______________________________

PAYMENT INFORMATION | TERMS & CONDITIONS

☐ Cash ☐ Credit/Debit Card

☐ Check ☐ CareCredit Card

By signing, I accept full financial responsibility of fees related to partial or complete physical examination and/or partial or complete consultation with a veterinarian and/or veterinary staff.

I acknowledge that no guarantees are made regarding services rendered, treatments performed, or products dispensed by PAW Health Network, Inc.

Regardless of outcome, including life or death, I accept full financial responsibility for services rendered, treatments performed, or products dispensed while the listed animal is or was under the care of PAW Health Network, Inc.

Should I decline diagnostic(s) and/or treatment(s), I release PAW Health Network, Inc., all employees, all owners and all affiliates of liability or loss by having gone against medical advice.

I understand that if timely payments are not made, any outstanding balance(s) will be sent to the Marathon County Court of Small Claims. I understand I will be responsible for all applicable court costs and fees, including actual attorneys' fees.

I understand that all written and/or verbal estimates are produced in good faith and may be ***accurate within a range of 15% the listed value****.*

I acknowledge that PAW Health Network, Inc. will be faxing/emailing a medical record to my primary care veterinarian. I, at any time, may request a medical record by fulfilling a ***Medical Record Request Form****.*

I consent that at any time PAW Health Network, Inc. may request and receive full medical records from any veterinary clinic at any time. I also acknowledge that any officer of the state may receive my medical record without consent or prior knowledge.

I agree to make an initial deposit prior to services rendered treatments performed, or products dispensed. I also agree to remedy any remaining charges upon completion or fulfillment.

SIGNATURE **DATE**

ARRIVAL TIME: **ACCOUNT NUMBER:** **EMPLOYEE:**

PAW HEALTH NETWORK, INC.

AUTHORIZATION RELEASE

I am ☐ the **owning caregiver** or ☐ the **acting agent** on behalf of the owning caregiver for the listed animal. I have the authority to make medical and financial decisions regarding its health and well being.

I/We are electing…

☐ Lab Work ☐ Hospitalization ☐ Sedation ☐ Pain Meds
☐ X-rays ☐ Catheterization ☐ General Anesthesia ☐ Medication
☐ Ultrasound ☐ Fluid Therapy ☐ Local Anesthesia

☐ Procedure ______________________________

☐ Other ______________________________

I acknowledge that the attending veterinarian and/or support staff has appropriately informed me of all diagnostic and therapeutic options that pertain to the listed animal's presenting complaint and clinical abnormalities.

I consent to the administration of medications that are determined necessary by the attending veterinarian(s) to reduce pain and/or suffering, previously discussed or without my knowledge in the best interest of the patient.

I understand that a good faith effort has been made to create an accurate estimate for cost of services and products. I acknowledge that any financial estimate is ***accurate within a range of 15%.***

If a surgical procedure is authorized, I acknowledge that unexpected conditions may arise during the procedure. I grant the authority to remedy such unexpected conditions as seen fit by the attending veterinarian(s).

I acknowledge that the attending veterinarian and/or support staff will attempt to contact me before remedies are made.

Should I be unavailable, I authorize attending staff to act in the best interest of the listed animal with or without my verbal consent.

I acknowledge that no guarantees are made with regard to the outcome of any services rendered or product sold.

I accept full financial responsibility for fees related to services rendered by parties of PAW Health Network, Inc. and/or any products sold.

I agree to make an initial deposit and will remedy any remaining charges on my account upon completion of services.

I understand that if timely payments are not made, any outstanding balance(s) will be sent to the *Marathon County Court of Small Claims*. I understand I will be responsible for all applicable court costs and fees including actual attorneys' fees.

I release PAW Health Network, Inc., all owners, all employees, and all affiliates of liability, loss, damages, and/or compensation associated with the outcome of any services rendered by employees or agents of PAW Health Network, Inc.

ESTIMATE RANGE

$**____________ - **$____________

INITIAL DEPOSIT

$____________

In the event of a life-threatening medical, surgical or anesthetic crisis:

☐ I wish for CPR to be performed, I understand it could cost up to an additional $350
☐ Do not resuscitate my pet, I do not wish for CPR to be performed

I certify that I have read and understand the contents of this release and consent

Signed ______________________________ Date ________________

I am providing **ONE phone number**, to be my/our primary contact phone number. I agree to be available at all times, with the ringer turned on. I/We may have conversations on speakerphone with multiple parties present, but I am responsible for disseminating information to all relatives and related parties. I understand doctors and staff do not have time to have multiple phone conversations with multiple parties while maintaining exceptional patient care.

Our ONE Primary Contact Phone Number Is ______________________________