# VCA Animal Referral & Emergency Center of America

1648 North Country Club Drive, Mesa, AZ 85201

**P** 480-898-0001 vcaareca.com

## New Client Record Form

*Thank you for giving VCA ARECA the opportunity to care for your pet.*

**Owner:** _____ **Co-owner:** _____
Last, First Last, First

**Authorized Owner Representatives or Family Members:** _____

**Address:** _____
Street Apt. #

_____
City State Zip Code

**Primary Phone #:** _____ **Alternate Phone #:** _____

**Email Address:** _____ **Alternate Phone #2:** _____

**Alternate Email:** _____ **Would you approve us sending you text messages such as Updates on your pet, Communications, and Appointment reminders?** ☐ Yes ☐ No

**How did you become aware of our hospital?**

☐ Advertisement ☐ Community Event ☐ Internet/Web Site ☐ Hospital Sign/Drove by

☐ Veterinarian Referral Doctor: _____ Hospital: _____

**My regular veterinarian is:** Doctor Name: _____

Hospital Name: _____ ☐ I do not have a regular veterinarian

### Consent for Exam, Treatment and/or Surgery

I am the owner, or a representative of the owner, of the animal presented and have the authority to execute this consent. I authorize and direct the veterinarians at the Animal Referral & Emergency Center of Arizona (and their designated assistants) to administer authorized treatment as needed on the basis of findings during the course of evaluation: to diagnose, prescribe, sedate, anesthetize, perform therapeutic procedures and/or surgery as their judgment may dictate to be advisable for the patient's well being. I understand I will be advised as to the nature of the procedures and the risks involved. I understand that no warranty or guarantee will be made as to the results or cure.

An estimate of these fees will be provided for the initial assessment and treatment for the animal presented. I realize that actual expenses may differ from the estimate dependent on the patient's condition and length of stay in the hospital. ARECA will try to contact me if emergency treatment is required. I also understand and will be responsible for expenses incurred in an emergency when I cannot be reached or there is no time to contact me.

**I will be fully responsible for monitoring the ongoing expenses and will be fully responsible for all expenses incurred through the animal's diagnosis and treatment.**

**ALL FEES ARE EXPECTED TO BE PAID IN FULL UPON COMPLETION OF THE VISIT.**
**A DEPOSIT OF 75% IS REQUIRED IF YOUR PET IS BEING HOSPITALIZED.**

Please indicate method of payment:

☐ Cash ☐ Discover ☐ MasterCard

☐ Visa ☐ American Express ☐ Care Credit Financing
(application & approval required)

In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agrees to pay all costs including said unpaid balance, a reasonable collection fee, finance charges, and/or attorneys' fees.

**Owner Signature:** _____ **Date:** _____

**PLEASE PRESENT IDENTIFICATION UPON COMPLETION OF THIS FORM**

CSR: _____