Groveway Veterinary Hospital
2423 Grove Way
Castro Valley, CA 94546-7105
(510) 581-6629
www.grovewayvet.com

DROP OFF CONSENT FORM

OWNER **ADDRESS**	**PHONE** **CELL** **EMAIL**
PATIENT NAME	**SEX**
SPECIES/ BREED	**COLOR**
DOB/Age	**WEIGHT**

Phone number(s) you can be reached at today:_____

Description of medical problem: _____

_____

_____

_____

How many days has the problem been occurring? _____

Is this a medical problem or condition that your pet is being treated for? _____

Please answer the following questions by circling all that applies:

Vomiting	No	Don't know	Yes (if yes, how many days?)_____		
Diarrhea	No	Don't know	Yes (if yes, how many days?)_____		
Coughing	No	Don't know	Yes (if yes, how many days?)_____		
Sneezing	No	Don't know	Yes (if yes, how many days?)_____		
Gagging	No	Don't know	Yes (if yes, how many days?)_____		
Weakness	No	Don't know	Yes (if yes, how many days?)_____		
Limping	No	Don't know	Yes (if yes, how many days?)_____		
Scratching	No	Don't know	Yes (if yes, how many days?)_____		
Eating	Normal	Don't know	Increased	Decreased	None (# of days?)_____
Water intake	Normal	Don't know	Increased	Decreased	None (# of days?)_____
Urination	Normal	Don't know	Increased	Decreased	None (# of days?)_____
Defecation	Normal	Don't know	Increased	Decreased	None (# of days?)_____
Energy	Normal	Don't know	Increased	Decreased	None (# of days?)_____

Authorization

I, the owner or agent of the above animal understand that by dropping my pet off for treatment I am authorizing the attending veterinarian to examine my pet at a cost of $55.00. Any other treatments, tests or procedures will be reviewed with you via a phone or in person conversation and an estimate will be given.

***Initial here** _____

I authorize necessary diagnostic testing and treatment up to $ _____, without further authorization by initialing below.

***Initial here** _____

Overnight Hospitalization (applies to ALL potential overnight patients)

- I understand that by initialing and signing below, I am acknowledging that Groveway Veterinary Hospital does NOT provide continuous, 24 hour care. There are no staff guaranteed to be on the premises in the off hours between 6 pm and 8 am the following morning, Monday through Friday; and after 2pm on Saturday. The evening treatments on Saturday and treatments due on Sunday, will be administered, under the instruction of the veterinarian in charge of the case, by a veterinary technician and/or veterinary assistant, competent in the administration of such tasks. In the case of any concerns or complications, that veterinarian will be contacted immediately to assist as needed.
- If you would prefer not to leave your animal overnight without continuous care, you may request information for a local veterinary emergency clinic, that can provide continuous, 24 hour care. You are responsible for transfer of your animal to and from the other veterinary clinic.

***Initial here** _____

I the owner or agent acknowledge that by signing below I am Authorizing Groveway Veterinary Hospital to perform medical or surgical treatment, as outlined above, for my pet. I acknowledge that I shall be supplied with an estimate for services, either written or verbally over the phone, which shall be signed or verified over the phone; so that I may be aware of the cost of these service and can make decisions and arrangements accordingly. I also acknowledge by signing below that fees for professional services are due upon release of the animal. In the case that you feel you may not be able to cover the full fees, it is your responsibility to make arrangements prior to services being rendered. Our staff can help you in accessing third party financing through Care Credit®. No credit is offered directly through Groveway Veterinary Hospital. For your convenience Groveway Veterinary Hospital accepts ATM/Debit, Visa, Mastercard, American Express, Discover, Cash, Check (with valid ID) and Care Credit® (OAC).

If you are NOT the owner, please check the box to confirm you have the authority to act on behalf of the owner of the animal described above

*Signature _____

Owner/Agents name _____

Date of Signature_____

A copy of this form will be available to the owner/agent upon request. The original will be retained by the practice.

Client ID #