Veterinary Specialty and Emergency Center
THOUSAND OAKS
Every Day Care Made Special

CLIENT INTAKE FORM

2967 N. Moorpark Rd
Thousand Oaks, CA 91360
P. 805-492-2436 F. 805-492-3228

CLIENT INFORMATION:

Last name: _____ First Name: _____ Middle Name: _____

Spouse Last name: _____ Spouse First Name: _____

Address: _____City:_____ State: _____

Zip Code_____ Primary phone: _____ Secondary phone: _____
☐Cell ☐Home ☐Work ☐Cell ☐Home ☐Work

Email address: _____ DOB: _____

PATIENT INFORMATION: Dog: ☐ Cat: ☐ other: ☐ _____

Pet's Name: _____Breed: _____Color:_____

☐ Male, intact ☐ Female, intact

☐ Male, neutered ☐ Female, spayed Age: _____ years / months or Birthdate: _____/_____/_____

Primary Care Veterinary Hospital: _____

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

I HEREBY AUTHORIZE THE DOCTOR ON DUTY (AND ASSISTANTS THE DOCTOR MAY DESIGNATE) TO ADMINISTER TREATMENT AS CONSIDERED THERAPEUTICALLY AND/OR DIAGNOSTICALLY NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID EVALUATION. I ALSO CONSENT TO THE ADMINISTRATION OF SUCH ANESTHETICS AND SURGICAL PROCEDURES AS ARE NECESSARY. I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT, THE REASONS WHY THE SURGERY IS CONSIDERED NECESSARY, ITS ADVANTAGES AND POSSIBLE COMPLICATIONS IF ANY, AS WELL AS POSSIBLE ALTERNATIVE MODES OF TREATMENT WHICH ARE EXPLAINED TO ME BY THE DOCTOR. I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED TO THE PATIENT AND CONSENT TO THE RELEASE OF MEDICAL INFORMATION TO THE ABOVE NAME FAMILY VETERINARIAN. I UNDERSTAND THE CLINIC AND ITS PERSONNEL DOES NOT GIVE ANY GUARANTEE THAT THE RECOMMENDED TREATMENTS/PROCEDURES WILL CORRECT OR CURE THE CONDITION FOR WHICH MY PET WAS PRESENTED. I UNDERSTAND THAT IF MY CHECK OR CREDIT CARD IS RETURNED UNPAID FOR ANY REASON THAT I WILL BE SUBJECT TO ADDITIONAL CHARGES AND THAT IF A COLLECTION AGENCY/ATTORNEY MUST BE USED TO COLLECT THE BALANCE OF THE CHARGES RESULTING FROM CARE RECEIVED BY MY PET AT VETERINARY SPECIALTY AND EMERGENCY CENTER, I WILL BE RESPONSIBLE FOR PAYING ANY COLLECTION COST/FEES.

DISPUTE RESOLUTION

ANY DISPUTE, CLAIM OR CONTROVERSY ARISING OUT OF OR RELATING TO THIS AGREEMENT OR THE PROVISION OF SERVICES OR PRODUCTS OF ANY TYPE THROUGH VETERINARY SPECIALTY AND EMERGENCY CENTER OF THOUSAND OAKS, INC. OR THE BREACH, TERMINATION, ENFORCEMENT, INTERPRETATION OR VALIDITY THEREOF, INCLUDING THE DETERMINATION OF THE SCOPE OR APPLICABILITY OF THIS AGREEMENT TO ARBITRATE, SHALL BE DETERMINED BY ARBITRATION IN VENTURA COUNTY, CALIFORNIA, BEFORE A SINGLE ARBITRATOR WITH EXPERIENCE IN COMMERCIAL ARBITRATION. THE ARBITRATION SHALL BE ADMINISTERED BY JAMS PURSUANT TO ITS JAMS' STREAMLINED ARBITRATION RULES AND PROCEDURES. JUDGMENT ON THE AWARD MAY BE ENTERED IN ANY COURT HAVING JURISDICTION. THIS AGREED PROCEDURE SHALL NOT PRECLUDE PARTIES FROM SEEKING PROVISIONAL REMEDIES IN AID OF ARBITRATION FROM A COURT OF APPROPRIATE JURISDICTION. IN ANY ARBITRATION ARISING OUT OF OR RELATED TO THIS AGREEMENT, THE ARBITRATOR SHALL AWARD TO THE PREVAILING PARTY, THE COSTS AND ATTORNEYS' FEES REASONABLY INCURRED BY THE PREVAILING PARTY IN CONNECTION WITH THE ARBITRATION. THIS AGREEMENT AND THE RIGHTS OF THE PARTIES HEREUNDER SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF CALIFORNIA, EXCLUSIVE OF CONFLICT OR CHOICE OF LAW RULES.

X

_____ _____

SIGNATURE OF RESPONSIBLE AGENT (MUST BE AT LEAST 18YRS OF AGE) WITNESS

Advanced Directive

In the unlikely event your pet should require heroic or invasive life-saving intervention (cardiopulmonary arrest and resuscitation), you will be contacted immediately. However, in order to give your pet the best possible outcome, please indicate which of the following you authorize VSEC to perform should we be unable to contact you.

_____ No Resuscitation (DNR)

_____ CPR

CLIENT ID #_____

PATIENT ID#_____

PATIENT NAME_____