



ANIMAL CANCER & IMAGING CENTER
STANDARD CONSENT & CLIENT INFORMATION FORM

Today's Date: _____

CLIENT INFORMATION

Owner's Last Name	First	Middle	Spouse
Street Address		City	State Zip
Home phone ()	Work phone ()		Cell phone ()
Referring Vet:		Clinic Name:	

If you would like your discharge letters e-mailed to you please provide your e-mail: _____

PATIENT INFORMATION

Pets Name:	Species:	Breed	Color
Spayed or Neutered? Yes No	Birth date	Sex:	

Treatment Authorization and Information/Photo release

I Hereby authorize ACIC to perform medical and initial diagnostic/surgical procedures on this animal as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants.

If you were referred to our clinic by another hospital or veterinarian, they will require a summary of your pet's care and treatment in order for your pet's care to continue without interruptions. ACIC considers that your identification of a referring veterinarian implies your authorization to release records and information to that referring veterinarian.

Information and/or photos may be used in teaching, forms, continuing education, Web site, veterinary literature, and the like. I authorize the release of case/patient information for such purposes; patient confidentially (names withheld) will be maintained.

Financial Policy

Payment is due as services are rendered. You may pay by cash, personal check, and accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory. There is a \$15.00 returned check fee.

Authorization

I am the owner of the above pet, or am acting as the agent for the owner, and accept full financial responsibility.

Signature _____ Date _____

