VRCC®
VETERINARY SPECIALTY & EMERGENCY HOSPITAL

HOSPITAL USE ONLY	
	Wt:
	Room#:
	Time:

Patient Intake Form

Client Information

First Name:	Last Name:	M.I.:
Additional Authorized Guardians:		
Mailing Address:		
City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:
E-mail:		
How did you hear about us? (Check all that apply)	☐ Family/Friend ☐ Family Veterinarian ☐ Event ☐ Internet/Facebook ☐ Magazine/Newspaper ☐ Previous visit to VRCC ☐ Radio/TV ☐ Walk-In ☐ Other_____	
Family Veterinarian/Hospital:	VRCC Departments Presenting Pet Has Visited:	

Patient Information

Pet's Name:	Species: ☐ Canine ☐ Feline ☐ Other	Color:
Breed:	☐ Male ☐ Female ☐ Male Neutered ☐ Female Spayed	Birthdate or Age:
Date of last Rabies vaccine:	Administered By:	1yr / 3yr (circle one)
Initial Presenting Problem:		

TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize VRCC departments to perform medical and initial diagnostic/surgical procedures on my pet as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors or assistants.

If I have been referred to this hospital by another veterinarian, I understand that they will require a summary of the care and treatment provided by the VRCC departments in order to ensure that my pet's care can be continued without interruption. I also understand that VRCC considers the identification of a referring veterinarian by me to be my authorization to release records and information to that veterinarian.

As leaders and teachers in the veterinary medical field, the Specialists and staff of VRCC may use medical case information for teaching, developing forms, providing continuing education, website and veterinary literature development, and social media updates. I authorize the release of case/patient information, including photographs for such purposes. Patient confidentiality (client names withheld) will be maintained.

By submitting any photo to VRCC, you agree to the following: I certify that I am 18 years of age or older, and I am the sole owner of the photograph(s) I submit to VRCC. I agree not to email any photograph(s) protected by copyright without the express permission of the owner of the copyright. I grant VRCC the right to reproduce, distribute, publish, display, edit, modify, create derivative works, and otherwise use the photograph(s) for any purpose in any form and in any media. I agree to indemnify VRCC for all damages and expenses that may be incurred in connection with the photograph(s), including but not limited to the publication of the photographs on www.vrcc.com and to use my name in connection therewith if VRCC so chooses.

In the event I transfer ownership, etc. to another party, I authorize release of medical information to the new owner, should they request it.

FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance.The balance is due upon discharge from the hospital. Payment may be by cash, personal check (with proper identification), or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

A service fee of $3.00 and 1.5% of the outstanding balance will be charged to your account monthly if not paid in full. If applicable, you will be responsible for any lawyer and/or collection agency expenses that may be incurred. Returned checks are subject to penalties under the Colorado Returned Check Law, C.R.S. 13-21-109. For additional information on the Colorado Returned Check Law, see www.ago.state.co.us/CADC/BadCheckLaw.cfm or call the Office of the Colorado Attorney General at 303-886-5304.

I understand that I, as the owner or agent, am financially responsible to VRCC for all charges relating to this patient. I have read and agreed to the treatment authorization. I have also read and accepted the financial obligations.

Signature: _____ Date: _____