

Wesley Chapel Veterinary Hospital
4879 Bruce B. Downs Blvd
Wesley Chapel, FL 33544
Phone: (813) 973-3951
Fax: (813) 973-4860
Email: wcv1@hotmail.com

Thank you for giving us the opportunity to care for your pet(s)! So that we may become better acquainted, please complete the following:

Client Information:

Owner (First): _____ (Last): _____ Spouse: _____
Address: _____ City, State, Zip: _____
Mobile Phone: _____ Secondary Phone: _____
Email: _____@_____

_____(initials): **I understand** that my email will be used for **reminders for my pet(s)** vaccinations, medications, and appointments, as well as any requested Estimates, Patient Records, Visit Summaries and/or Treatment Plans.

_____(initials): **I consent** to receiving SMS reminders for my pet(s) scheduled appointments.

Pet's Name	Species (Dog / Cat)	Breed	Color	Age	M/F	Neutered/ Spayed/Intact

_____(initials): **I acknowledge** that I am 18 years of age or older, and I am the legal owner, or an authorized agent of the owner, of the pets listed above.

Please review and initial each of the following policies. If you have any questions, our Front Desk Staff is happy to assist you.

Financial Policy:

_____(initials): **I understand that payment is due at the time of service**, all charges must be paid at the time of release, and some procedures may require a deposit.

_____(initials): **I am aware** that the accepted forms of payment include: **cash, Apple Pay, Tap-To-Pay, debit card or credit card (AMEX, Visa, Mastercard, Discover), and Care Credit. WE DO NOT ACCEPT CHECKS.**

_____(initials): **I acknowledge** that, in the event of non-payment, if my pet's condition has been stabilized, all services may be terminated.

_____(initials): **I agree** to pay all collection costs, including court costs, attorney fees, and any late charges that occur due to non-payment.

Prescription Policy:

_____(initials): **I am aware** that, **in accordance with s. 474.274 Florida statutes**, I may request a written or electronic prescription for any medications prescribed by the Veterinarian during my visit, that may be filled by my pharmacy of choice. ***If requested at a later date, it may take up to 24 hours for a written or electronic prescription to be available, and a \$15 administrative fee for records review and verification may apply.***

_____(initials): **I am aware** that I also have the option of filling my pet's prescriptions at Wesley Chapel Veterinary Hospital. Prescription refills will be ready for pick up ***24-72 hours after the request is made.***

Client Expectations:

_____(initials): **I understand** that I am expected to arrive on-time for any scheduled appointments. If I am ***more than 15 minutes late, I will need to reschedule the appointment*** with Front Desk Staff.

_____(initials): **I understand** that any appointment cancellations should be made at least 24 hours in advance, and any surgery ***cancellations should be made at least 48 hours in advance. Failure to cancel or reschedule*** in a timely fashion, or a **No Show** appointment or procedure will result in a ***charge of up to \$60 that must be paid before any future appointments will be scheduled.***

_____(initials): **I understand** that I am expected to follow the treatment plan recommended by the Veterinarian, and to administer any prescribed medications exactly as directed. ***Administering medications to animals other than the patient it is prescribed for is grounds for the termination of the Veterinarian-Client-Patient Relationship.***

Consent to Treat:

I, the undersigned owner or authorized agent of the owner of the pets listed above, authorize Dr. Lucado, DVM and his staff to perform procedures, diagnostics, and/or administration of medications and/or vaccinations within accepted guidelines as deemed advisable and/or necessary for my pet(s). I understand the risks of any procedure, and that no guarantee can be made as to the results or cure of any therapy.

Client Signature

Date