



Client Consent and Payment Form

Client and patient information and authorization to provide veterinary care

Client Information

Client/Owner Full Name

Date

Preferred Name

Address

City

State

ZIP

Primary Phone

Email

Alternate Phone

Authorized Agent / Additional Decision-Maker

Agent Phone

Patient Information

Patient 1

Pet Name

Species

Breed / Color

Age

Sex

Spayed / Neutered

Microchip Number

Allergies, medication reactions, handling concerns, or other important information

Patient 2

Pet Name

Species

Breed / Color

Age

Sex

Spayed / Neutered

Microchip Number

Allergies, medication reactions, handling concerns, or other important information

Patient 3

Pet Name

Species

Breed / Color

Age

Sex

Spayed / Neutered

Microchip Number

Allergies, medication reactions, handling concerns, or other important information



Client Consent and Payment Form

Additional patients and authorization to provide veterinary care

Additional Patient Information

Patient 4

Pet Name	Species	Breed / Color	Age
Sex	Spayed / Neutered	Microchip Number	

Allergies, medication reactions, handling concerns, or other important information

Patient 5

Pet Name	Species	Breed / Color	Age
Sex	Spayed / Neutered	Microchip Number	

Allergies, medication reactions, handling concerns, or other important information

Patient 6

Pet Name	Species	Breed / Color	Age
Sex	Spayed / Neutered	Microchip Number	

Allergies, medication reactions, handling concerns, or other important information

Authorization for Veterinary Care

I certify that I am the owner of the patient(s) on my account, or that I am authorized by the owner to make medical and financial decisions. I authorize Best Friends Animal Hospital and its veterinarians and staff to examine my pet and to provide routine, medically appropriate care that I approve after the veterinarian discusses the recommended plan, reasonable alternatives, expected benefits and material risks, and estimated costs. I understand that results cannot be guaranteed.

This form does not replace procedure-specific consent. Surgery, anesthesia, dentistry, euthanasia, hospitalization, and other significant procedures may require a separate estimate and consent. I may ask questions, decline recommendations, or withdraw consent before treatment, except when care has already been performed or is urgently required under a separate authorization.

☐ I authorize examination and treatment as described above for all current and future patients on my account.

Optional standing limit for approved services per visit

Leave blank if no standing limit

\$

Contact me before exceeding this amount.

Emergency and CPR Direction

If my pet experiences cardiac or respiratory arrest while at the hospital, I direct the medical team to follow the option selected below. I understand CPR may involve chest compressions, intubation, emergency drugs, oxygen, and other measures; success is not guaranteed and additional charges may apply.

- ☐ ATTEMPT CPR - Begin reasonable resuscitation efforts and contact me as soon as possible.
- ☐ DO NOT RESUSCITATE - Allow natural death and provide comfort care.

Select one. This direction applies to routine visits unless replaced by a more recent written direction. A procedure-specific or hospitalization consent controls when it contains a different CPR choice.

Client Initials

Date

Financial Policy

Payment is due in full at the time services are provided or when my pet is discharged.

Unless the hospital approves another written arrangement in advance, I accept responsibility for all charges for services I authorize or that my authorized agent approves.

Estimates are approximations, not guarantees. A pet's condition or response may require changes in the treatment plan. The hospital will make reasonable efforts to obtain my approval before materially exceeding an estimate, except as separately authorized for urgent care.

A 3% surcharge will be added to credit card payments. No surcharge fee will be added to debit card, cash, or check transactions. Check payments must be approved by management. Any surcharge will be disclosed as required at the time of payment.

I am responsible for fees permitted by law for returned payments and reasonable collection costs, including court costs and attorney fees, if incurred. I understand that unpaid balances may be referred for collection after notice.

☐ I acknowledge and agree to the Financial Policy above.

Contact and Communication Preferences

I authorize the hospital to use the contact information I provide for appointment reminders, patient-care messages, estimates, invoices, payment notices, prescription updates, and follow-up communication. Standard message/data rates may apply. I may update these preferences at any time.

- ☐ Phone calls ☐ Detailed voicemail ☐ Text messages
- ☐ Email messages ☐ Online portal / digital forms

For non-urgent communications, I prefer:

- ☐ Phone ☐ Text ☐ Email

Medical Records and Care Coordination

I authorize the hospital to obtain and disclose my pet's medical records and related information to veterinarians, emergency and specialty hospitals, diagnostic laboratories, pharmacies, pet insurers, and other service providers as reasonably needed for treatment, care coordination, prescriptions, payment, or claims that I request. I understand records otherwise remain private except as authorized by me or required by law.

☐ I authorize medical-record exchange for the purposes stated above.



Client Consent and Payment Form

Photo permissions, acknowledgments, and signature

Clinical Photography

I understand the medical team may create photographs, videos, radiographs, or other images when reasonably needed to document, diagnose, or treat my pet. These materials become part of the medical record and are not authorized for public marketing by this section.

Initials I acknowledge the use of clinical images for my pet's care and medical record.

Public Photo and Social Media Release Optional

Choose one option. A refusal will not affect care. If I grant permission, I authorize Best Friends Animal Hospital to photograph or record my pet and use the content for clinic education, website, social media, advertising, and promotional materials. I understand public posts may be shared by others and cannot always be fully removed after publication.

☐ YES - My pet may be photographed or recorded; do not identify me by name.

☐ YES - My pet and I may appear; the clinic may use my first name only.

☐ NO - I do not authorize public or promotional use.

Client Initials Date

Additional Acknowledgments

Initials This agreement applies to every current patient on my account and to any new patient added to my account in the future, unless the hospital and I sign a later form that replaces it.

I will provide complete and accurate information about my pet's health, medications, behavior, and known exposures.

I will keep my contact information current and identify anyone authorized to make decisions or incur charges on my account.

I understand contagious disease, bite, scratch, and handling risks may require reasonable safety precautions or referral.

I understand medication refills and certain treatments require a current veterinarian-client-patient relationship and may require an examination.

I received an opportunity to ask questions and understand that I may request a copy of this signed form.

Client Agreement and Signature

By signing, I confirm that I have read and understand this form, that my selections accurately state my choices, and that I agree to its treatment and financial terms. This authorization remains in effect until I revoke or replace it in writing, except that revocation does not affect services already provided or obligations already incurred.

Client/Authorized Agent Signature Date

Printed Name Relationship to Pet Owner

Clinic use note: Review incomplete or conflicting selections before treatment. Obtain separate informed consent for significant procedures. This operational form is not legal advice and should be reviewed by Minnesota counsel before implementation.