Mason Family Pet Hospital, LLC
HOSPITAL CHECK-IN FOR **CATS**
SURGICAL & MEDICAL RELEASE FORM

***** PLEASE READ CAREFULLY, MARK ALL APPLICABLE ANSWERS, AND SIGN *****

Owner/Agent _______________________ Pet's Name _______________

1) My cat is here for the following scheduled services: ______________________________________

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2) While my cat is hospitalized, please perform the following additional services if medically indicated:

☐ Please perform a complete examination of my cat ($29.50). This is highly recommended if your pet has not been seen by us in the past year or has any health problems. **This is required for all patients that are receiving vaccines.**

☐ Test for Feline Leukemia and/or F.I.V. ($29.50 or 39). Recommended for all cats that have never been tested. Combo FELV/FIV test recommended for cats over 6 months.

☐ Update necessary vaccines ($17-18 each). Even cats that are TOTALLY indoors should be vaccinated. Check this box ☐ if your cat is totally indoors.

☐ Pull a stool sample to check for parasites ($12.50)

☐ Dispense medication if indicated for:

☐ Fleas - Cheristin ($20.61 single dose to $51.58 multidose 3-pack)

☐ Earmites ($23)

☐ Worms ($8-18)

☐ Implant Home Again microchip for identification ($46)

3) Depending upon the procedure, the veterinarian may wish to administer extra post-operative pain medication(s) and dispense some for home use. These medications are usually optional and could add from $5 to $25 to your invoice. Do you want pain medicine if recommended?

☐YES ☐ NO

4) I hereby authorize Mason Family Pet Hospital, llc and its designated associates, technicians, or assistants to treat, anesthetize, prescribe medication for, and perform specific diagnostic tests or surgery on my pet. I have been advised as to the nature of the procedures or operations. I realize that the results cannot be guaranteed. I understand the risks associated with these procedures and know that all reasonable precaution will be taken against injury, escape, or the death of my pet. I will not hold Mason Family Pet Hospital, llc liable in the event of such.

If emergency treatment is required and I cannot be reached, I authorize Mason Family Pet Hospital, llc to perform such procedures as are necessary to preserve the life of my pet until I can be contacted.

I accept full financial responsibility for treatment of my pet and understand that payment in full is due upon release of my pet from the hospital, or when service is otherwise terminated.

I certify that I have read, fully understand, and agree to this authorization and release.

X ___________________________________ ____________________
(Signature of owner or authorized agent) (MFPH employee witness)

_________________________________ ____________________
(Phone # where I can be reached TODAY) Date