



Acupuncture Treatment Consent Form

Owner's/Agent's Name _____ Date _____

Address _____ City/State _____ Zip _____

Home Phone _____ Additional Phone _____

Email Address _____

Pet's Name _____ Species: Dog Cat Other _____

Breed _____ Color _____ Age _____ Weight _____

Sex: M F Spayed/Neutered

Please provide the name of the veterinary clinic/hospital that referred you to us:

Veterinary Clinic/Hospital Name _____ Phone _____

Have any other veterinarians seen your pet within the last 3 years?

Veterinary Clinic/Hospital Name _____ Phone _____

Authorization for Hospice Care Treatment

I certify that I am the legal owner/duly authorized agent for the owner of the animal described above and do hereby give Dr. Carmack, Hampton Roads Veterinary Hospice PLLC, and any authorized agents, staff, or representatives full and complete authority to examine, prescribe for, or treat the above-described pet. I agree that Dr. Carmack, Hampton Roads Veterinary Hospice PLLC, and any authorized agents, staff, or representatives shall not be liable for any direct, indirect or consequential damages resulting from such care.

I understand that Hampton Roads Veterinary Hospice does not provide complete veterinary care and that hospice care is focused on preserving quality of life for as long as possible and is NOT focused on curing medical conditions or providing routine veterinary care, surgical care or emergency treatment/transport. I have been advised that if additional diagnostics, procedures, or more aggressive care is recommended for my pet that I will be referred to my primary care veterinarian, an emergency hospital, or a specialty care hospital.

I assume full responsibility for the actions of the animal described above and all charges incurred in its care. I also understand that all professional fees are due at the time services are rendered.

I have carefully read and fully understand the above stated provisions.

Owner/Agent Signature (circle one)

Date