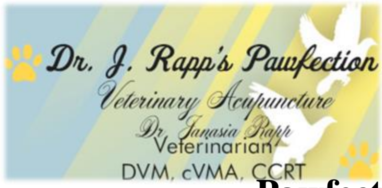

acuvet@pawfectionofhelpinghands.com
Phone: (719-201-6185)

Pawfection of Helping Hands- Veterinary Integrative Medicine
New Patient Form

DATE: ________________________

Please read thoroughly and complete entire form. Please sign and submit form, along with your pet's medical records if available. Thank you.

*I give permission for photos/videos of my pet and their health story to be used for social media, speaking events, and referral/promotional materials for Pawfection of Helping Hands (Dr. J. Rapp's Pawfection). Initial one: Yes ______ No _______

Client's Name: ____

Email address: ____

Cell Phone: ____

Home Phone: ____

Occupation: ____

Address:

Street:	City:
State:	Zip code:

How did you hear about Pawfection of Helping Hands: ________________________________

____

Previous Veterinary Office (if applicable): ____

Pet's name: ____

Date of Birth: _____________ Age:_________ Species:______________________________

Breed: ____

Color: ____

Circle one: Spayed Female Neutered Male Female Male

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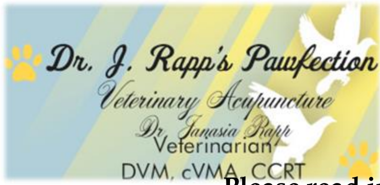
Phone: (719-201-6185)

Medications (Name/ Amount/ Frequency given per day):
Nutritional/Herbal Supplements:
Allergies:
Diet Information: Brand of food: ____wet/ dry? Cups of food per feeding: ______________________________ Amount of times fed per day (Can say “free-fed” if no exact amount): ______________________



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Please read instructions and consent form thoroughly. Please sign at the bottom of page.

CONSENT FORM:

I certify that I am the pet's parent/owner (or agent for the pet's parent/owner) of the patient noted above, 18 years of age or older, and **I have the authority to execute consent for these procedures**.

I understand that an additional person (Veterinary Technician) will travel to appointment locations with the Veterinarian for treatment assistance & safety purposes. I understand that a Veterinarian Technician may assist during wellness exams & necessary treatment(s), as deemed necessary by the Veterinarian.
I also do hereby authorize Pawfection of Helping Hands' veterinarians and technicians to examine my pet and administer treatment as is considered necessary for my pet's condition.

I understand that I assume all financial responsibility for services rendered, and that full payment is due at the time the services are rendered. Although unforeseen events rarely occur resulting from acupuncture and/or laser sessions, if any event were to occur, I am aware that I am not relieved of any obligation to all reasonable costs incurred regarding this patient. Payment Types Accepted include: Credit/Debit cards (Visa, MasterCard, Discover, American Express, JCB, UnionPay), Bank/Cashier's Check, Cash.
****No Personal Checks accepted****
****Transaction fee of $3 will apply for Credit/Debit card usage****
****Cancellations and Rescheduling 24 hours before appointment****

I understand that there is a "no-show appointment" fee of $25, if cancellation is not made at least 24hrs prior to appointment. Please check box ☐

I give Pawfection of Helping Hands the authority to request records for my pet(s) at previously utilized veterinary clinics and/or hospitals.

***I certify that I have read and fully understand all the above information and terms regarding treatment of my pet/patient and what is required.**

Printed Name: ---

Signature: ____ Date: _____________

Pet's Name: ____