Comet Veterinary Care
Carpinteria, California
Cometvet@gmail.com
(805) 664 - 1106

Client Information and Authorization Form

Client Name: _____

Address: _____

Phone: _____ Email: _____

Authorized Representatives:

I authorize the following individuals to make treatment decisions and/or request medications and supplements for my animal(s):

1. Name: _____
   Relationship:_____
   Phone: _____Email: _____
2. Name:_____
   Relationship: _____
   Phone:_____Email:_____

Animal(s) Information (Use additional pages if needed):

Animal Name:_____Species: _____
Age: _____ Sex: _____ Breed: _____
Color: _____ Microchip #: _____
Use/Purpose: _____

Vaccination History (Last vaccination +/- Coggins):

_____

Boarding Location: _____
Allergies or Special Concerns: _____
Trainer/Petsitter (if applicable): _____Phone: _____

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Payment Agreement:

I understand payment is due within 30 days of service. I accept responsibility for all charges including those requested by my authorized representatives. A monthly 1.5% late fee may apply. _____ (initial)

A credit card must be on file to open an account. This card will be stored securely and charged for any unpaid balances beyond 30 days. _____ (initial)

Please choose one:

1. Recurring credit card payment: Enroll me in a membership program (initial selection below). My card will be charged monthly without prior notification. I understand I will receive a monthly statement. Written notice is required to cancel.
    a. **Level 1 membership** $300/month, +$50 for additional animal

- Unlimited telemedicine consultations
- One exam monthly
- Procedures covered
- Annual wellness blood panel
- 1 annual radiograph study
- Annual vaccinations
- Domestic travel certificates

INITIALS _____

    b. **Level 2 membership** $250/month, +$50 for additional animal

- Unlimited telemedicine consultations
- One exam monthly
- Annual wellness blood panel
- 1 annual radiograph study
- Annual vaccinations
- Domestic travel certificates

INITIALS _____

    c. **Level 3 membership** $150/month, +$50 for additional animal

- Unlimited telemedicine consultations
- One exam monthly
- Annual wellness blood panel
- Annual vaccinations

INITIALS _____

2. I prefer payment per invoice. If no payment is received within 30 days, I authorize my credit card to be charged for any outstanding balances.

INITIALS _____

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Acknowledgment and Consent:

I, (please print) _____, confirm that I am the owner or responsible party for the animals listed. I am over 18 and authorized to provide consent for treatment. I have been informed of the potential risks, benefits, alternatives (including no treatment), and prognosis for recommended procedures. I understand I may refuse any treatment, and I consent to veterinary care as discussed.

INITIALS _____

I acknowledge that mobile services may involve environmental variables (e.g., weather, location-specific hazards) that could affect outcomes

INITIALS _____

I understand telemedicine limitations (e.g., no hands-on exam), that it requires an established VCPR via in-person evaluation, potential for technical issues, and the need for in-person follow-up if advised. I consent to telehealth under these terms, with records handled securely per privacy laws.

INITIALS _____

I authorize photos/videos of my animal(s) for medical records, education, or marketing (anonymized unless specified).

YES / NO

Any disputes arising from services will be resolved through mediation/arbitration in California per VMB guidelines, waiving jury trial rights.

INITIALS _____

I have read and understand this agreement. I agree with the terms outlined above.

Signature: _____

Date: _____

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Credit Card Authorization (if applicable):

Card Type: Visa / MasterCard / Amex / Discover

Card Number: _____

Expiration Date: _____

CVV: _____

Alternative accepted forms of payment: cash, Venmo,

If insured:

Company: _____

Policy Number: _____

Insurance Phone: _____

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Age: ______ Sex: ____________ Breed: ____________________
Color: __________________ Microchip #:__________________
Use/Purpose: ____
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Boarding Location: _____________________________________
Allergies or Special Concerns:______________________________
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