

AUTHORIZATION FOR PROFESSIONAL SERVICES

The following information is necessary in order for us to serve you better and give you accurate information and personal attention: **PLEASE READ AND FILL OUT THE FORM COMPLETELY**

OWNER NAME _____ PET NAME _____
SPECIES _____ BREED _____ SEX _____ COLOR _____
ADDRESS _____ CITY _____ ZIP _____

I hereby authorize the performance of the following procedures, surgical or non-surgical:

The nature of such service has been described to me to my satisfaction and I realize that no guarantee or warranty can ethically or professionally be made regarding the results or cure. I understand that **I assume financial responsibility for all services rendered, and that payment in full is due on the date the services are performed.** I also understand that my animal must be current on all required vaccinations in order to be hospitalized, and that if he/she is healthy enough in the judgment of the Doctor to receive required vaccines, they will be given in accordance with hospital policy and I will assume the costs therein.

PLEASE NOTE: All procedures requiring hospitalization require a deposit at the time your pet is admitted. Our policy is to collect the high estimate amount. Any overpayment will be refunded to the client when the procedure is complete. Please inform us if you have any questions.

THIS NOTICE APPLIES TO DENTAL PROCEDURES ONLY. Please be advised that tooth extraction is performed at Dr. Ivan's discretion. We do not pause a dental procedure to consult with an owner prior to an extraction because of the undue risk this poses to your pet under anesthesia. Please advise us if you have any questions. Thank you.

ADDITIONAL FEES WILL APPLY TO FEMALE ANIMALS IN HEAT OR PREGNANT AS DETERMINED BY THE DOCTOR, MALE ANIMALS WITH RETAINED TESTICLES, AND/OR AGGRESSIVE ANIMALS REQUIRING SPECIAL HANDLING/DRUGS**

ALL PETS WILL BE CHECKED FOR FLEAS/TICKS UPON ENTERING OUR KENNELS. IF THESE PARASITES ARE FOUND, TREATMENT WILL BE ADMINISTERED AT AN ADDITIONAL \$15 COST PER PET.

BY SIGNING BELOW, YOU ARE AGREEING TO BE RESPONSIBLE FOR ANY AND ALL COSTS INVOLVED WITH THE ABOVE PROCEDURE(S).

DATE: _____ TIME: _____ **PRIMARY CONTACT PHONE #** _____
ALT. PHONE # _____ EMAIL ADDRESS _____

SIGNED (OWNER OR AGENT OF OWNER):

X _____

*Continuous presence of personnel when the hospital is closed may not be provided.
Please inform us if you have any questions or concerns.*