

Treatment/Admission Form

Patient's Name: _____ Date of Procedure: _____
Client's Name: _____ **Emergency Phone:** _____

___ I, the undersigned owner of, agent of the owner of, or Good Samaritan responsible for seeking veterinary care for the pet named above. I consent to the examination of this pet by the staff veterinarian at Quail Hollow Animal Hospital.

___ I understand that after consultation with me, the hospital's doctors may prescribe medication for, treat, hospitalize, sedate, anesthetize, and or perform surgery on my pet. I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss these risks with the attending doctor or directed agent before the procedure is initiated.

___ I **DO/DO NOT** give permission to Quail Hollow Animal Hospital to provide such treatment should an unexpected life saving emergency care situation occur, and the staff at Quail Hollow Animal Hospital are unable to contact me, and I agree to pay for such care.

___ I understand that an estimate of the fees for veterinary services will be provided to me. I am encouraged to discuss any concerns I have with the fees related to such services before initiated. I agree to pay a deposit of 75% of the estimated fees. I agree to assume financial responsibility for the remaining fees and provide payment via cash, credit card, or check at the time my pet is discharged from the hospital.

___ I understand that in the event that my pet is hospitalized for more than 48 hours and the attending doctor or agent is unable to contact me, it is my responsibility to call the hospital every 24 hours to inquire as to the medical status of my pet and the fees incurred for medical care up to that day.

___ I understand that veterinary care during the night hours or weekends are provided at the discretion of the attending veterinarian. Continuous personnel presence may not be provided during these hours. I can request that my pet be transferred to a 24-hour care facility, the transportation and financial obligation to this facility is my own responsibility, not Quail Hollow Animal Hospital.

___ I further agree that I, or an undersigned agent of mine, will pick up my pet and pay for all accrued charges within 24 hours of receiving oral notification that my pet is ready to be discharged from Quail Hollow Animal Hospital. I agree that if I fail to comply with this policy, this practice may handle this abandonment in a manner that is in the best interest of the pet and the hospital.

Signature of Owner or Agent

Date