

AUTHORIZATION FOR HOSPITALIZATION AND TREATMENT

I certify that I am at least 18 years of age.

Owner _____ Pet's Name _____

Address _____ Breed _____

City _____ State _____ Zip _____ Sex _____

I hereby authorize the doctors of Goodlettsville Animal Hospital, P.C. to hospitalize and treat my pet. The diagnostic work-up and/or treatment plan has been described to me to my satisfaction. I realize there can be no guarantee regarding the outcome of my pet's treatment.

I understand that I assume financial responsibility for all services rendered, and that payment is due upon the completion of these services.

I understand that conditions may arise during the course of treatment that require altering the original treatment program, and this will result in a change of fees. We wish to be able to stay in contact with you in case any changes in treatment or charges must be made.

(_____) I wish to be notified before my bill exceeds \$_____, regardless of the situation.

(_____) I intend to keep in close communication so I can be informed of any changes. However, if I cannot be reached, I expect all necessary procedures, within reason, to be performed. The fees for such services will be added to the original estimate.

Upon dismissal of your pet, how do you intend to pay:

(___) Cash (___) Charge Card (___) Check (___) Other

PROCEDURE BEING PERFORMED TODAY: _____

SIGNATURE: _____ DATE: _____

We will need a phone number where someone can be reached at all times in case our Doctors need to talk with you. _____