Goodlettsville Animal Hospital

Authorization for Hospitalization and Treatment

Owner Full Name _____ Pet Name _____

Address _____ Breed _____

City _____ State _____ Zip _____ Sex _____

I hereby certify that I am at least 18 years of age. I authorize the doctors of Goodlettsville Animal Hospital 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 is 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 in full upon the completion of these services.

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

_____ I wish to be contacted before my bill exceeds $ _____.

_____ 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. I understand that fees for such services will be added to the original estimate and are my responsibility.

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

____ Cash ____ Credit Card ____ CareCredit ____ Check

Procedure being performed: _____

Owner Signature _____ Date _____

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

Primary Name/Number _____

Secondary Name/Number _____