ALBANY COUNTY VETERINARY HOSPITAL

MEMBER HOSPITAL AAHA AMERICAN ANIMAL HOSPITAL ASSOCIATION

1506 WESTERN AVENUE ALBANY, NEW YORK 12203

DONALD F. DRIES, D.V.M. TELEPHONE (518) 456-6333

TREATMENT AUTHORIZATION AND CONDITIONS OF ADMISSION

I CERTIFY THAT I OWN THE ANIMAL NAMED BELOW, OR AM RESPONSIBLE FOR IT, AND I HEREBY CONSENT AND AUTHORIZE ALBANY COUNTY VETERINARY HOSPITAL, ITS STAFF, OR VETERINARIANS TO BOARD, MEDICATE, TREAT AND HOSPITALIZE THE ANIMAL.

I HAVE BEEN ADVISED AS TO THE NATURE OF THE PROCEDURES OR OPERATIONS AND THE RISKS INVOLVED, AND HAVE HAD THE OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED.

I AGREE TO ALLOW MY PET TO BE IMMUNIZED, IF NO PROOF OF SUCH IS AVAILABLE, AND IT IS MEDICALLY ACCEPTABLE. IN ADDITION, I ACKNOWLEDGE THAT NO ASSURANCE OR GUARANTEE HAS BEEN MADE EXCEPT FOR REASONABLE PRECAUTIONS AGAINST INJURY OR ESCAPE, AND THAT RISKS AND PROBABILITIES OF COMPLICATIONS EXIST IN ANY SURGERY, ANESTHESIA, OR MEDICAL TREATMENT.

I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF ALL FEES INCURRED AND PROMISE TO PAY IN FULL WHEN MY PET IS RELEASED. I MAY REQUEST AN ESTIMATE FOR SERVICES RENDERED AND AM ALSO ENTITLED TO PERIODIC UPDATES ON MY PET'S CONDITION, AND THE CONTINUING COST OF TREATMENT.

ANY PARAGRAPH, OR STATEMENT MADE, IN THE AGREEMENT THAT SHALL BE DEEMED INVALID SHALL NOT INVALIDATE THE REMAINDER OF THIS AGREEMENT.

I WILL ALLOW THIS AGREEMENT TO BE IN EFFECT THROUGH THE LIFE OF THE ANIMAL NAMED BELOW, FOR SUBSEQUENT HOSPITAL STAYS.

NAME_____

SIGNATURE_____

DATE_____

PET'S NAME_____