

Authorization for Medical Treatment

Client's Name _____

Pet's Name _____

Medical Treatment(s) to be performed:

I, the undersigned owner or agent of the owner of the pet identified above, certify that

I am _____ I am not _____ (check one) eighteen years of age or over.

I authorize the veterinarian(s) at Castlegar Veterinary Hospital to perform the above procedure(s). I also agree 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 any concerns I have about those risks with the attending veterinarian before the procedure is initiated. My signature on this form indicates that any questions I have regarding the following issues have been answered to my satisfaction:

- The medical and/or surgical treatment alternatives for your pet
- Sufficient details of the procedures to understand what will be performed
- How fully your pet might respond or recover and how long it could take
- The most common and serious complications
- The length and type of follow-up care and home restraint required
- The estimate of the fees for all services and any necessary payment arrangements

I understand that an estimate of the costs for veterinary services will be provided to me and I am encouraged to discuss all fees attendant to such care before services are rendered and during my pet's ongoing medical treatment. While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no guarantee or warranty has been made regarding the results that may be achieved. If my pet is hospitalized, I agree to pay a deposit of _____% of the estimated fees, assume financial responsibility for the remaining fees, and provide payment via cash, debit or credit card at the time my pet is discharged from the hospital. In the event my pet is hospitalized for more than twenty-four hours and the attending doctor is unable to reach me, I understand it is my responsibility to call the hospital at least every twenty-four hours to inquire as to the medical status of my pet and the fees incurred for medical services up to that day.

Should unexpected life-saving emergency care be required and the hospital staff is unable to reach me, the staff

has ____ **does not have** ____ (check one) my permission to provide such treatment and I agree to pay for such services.

I understand that veterinary care during night time hours and/or weekends is provided at the discretion of the attending veterinarian. Continuous presence of personnel may not be provided during these hours. I accept that veterinary medicine is an inexact science and that no guarantee of successful treatment has been made.

I have read and fully understand the terms and conditions set forth above.

Signature of Owner or Agent

Date

Signature of Parent or Legal Guardian
(If owner/agent less than 18 years of age)

Date

(Phone number(s) at which owner or agent can be reached today and/or tomorrow)