STEVENSON VETERINARY CLINIC TREATMENT AND ADMISSION CONSENT FORM
7101 E. Loop Road, Stevenson, WA 98648 (509) 427-8763 Karen E. Ashley, DVM

Pet's Name_________________________ Species___________________ Sex______

I, the undersigned owner of, agent of the owner of, or Good Samaritan responsible for seeking veterinary care for the pet identified above, certify that **I am**___ **I am not**___ (check one)eighteen years of age or over. I consent to the examination of this pet by staff veterinarians at Stevenson Veterinary Clinic. 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. Should unexpected life-saving emergency care be required and the attending veterinarian is unable to reach me, the hospital staff has my permission to provide such treatment, and I agree to pay for such care.

I understand that an estimate of fees for veterinary services will be provided to me and that I am encouraged to discuss all fees related to such care before services are rendered and during my pet's on going medical treatment. If my pet is hospitalized, I agree to pay a deposit of 50% of the estimated fees. I agree to to assume financial responsibility for the remaining fees and will provide payment via cash, credit card, or check at the time my pet is discharged from the hospital. In the event my pet is hospitalized for more than forth-eight hours and the attending doctor is unable to reach me, I understand it is my responsibility to call the hospital at least every forty-eight hours to inquire as to the medical status of my pet and the fees incurred for medical services up to that day. I agree to pay a monthly billing and financing fee equal to 1.5% of any unpaid balance.

I understand the veterinary care during nighttime 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 further agree that I, or an authorized agent of mine, will pick up my pet and pay for all accrued charges within five days of receiving written or oral notification that my pet is ready to be released from the hospital. Such notice will be given at the address maintained on the hospital's patient/clinic record. 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 interests of the pet and the hospital.

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Signature of Owner or Agent Date

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Signature of Parent of Legal Guardian (if owner/agent is less than 18 years of age Date

Phone Numbers where I may be reached____