COUNTRY CLUB **Animal Hospital**

HOSPITALIZATION AUTHORIZATION FORM

PET OWNER: ____

OWNER'S ADDRESS: ____

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PHONE NUMBER: ____________________________ CELL: ______________________________

I authorize Country Club Animal Hospital (CCAH) and its staff to contact me via phone and text messages.

Consumer information is not shared with third parties for marketing purposes.

PET'S BREED: _______________ NAME: ________________ PET'S COLOR: ______________ SEX___________

I certify that I own the above described pet and I do hereby authorize Country Club Animal Hospital (CCAH) and its staff to hospitalize my pet, and to administer vaccinations, medications, laboratory tests, X-rays anesthetics, surgical procedures, or treatments that the Doctors of Country Club Animal Hospital (CCAH) may deem necessary for the health, safety, or well-being of the above pet while he/she is under their care and supervision.

If my pet should **REFUSE FOOD, SOIL ITSELF, BECOME MORE ILL OR DECEASE** while at CCAH, I will hold CCAH and its staff free of any responsibility and/or liability in the absence of gross negligence.

SPECIAL NOTES:

An **APPROXIMATE QUOTATION** of fees for a treatment plan will be provided **UPON REQUEST** and an appropriate deposit may be required. I further realize that I am responsible for payment-in-full for the above noted procedures and treatments at the time my pet is discharged. If I neglect to pick up the animal within five (5) days of the time that my pet is deemed ready for release from CCAH by the Doctors of CCAH, CCAH may assume that my pet is abandoned. CCAH is then authorized to reassign ownership of my pet as CCAH sees fit in order to discharge him/her from CCAH. Abandonment does not release me from my obligation for the payment of all charges incurred until my pet's release from CCAH.

The burden to keep in constant touch with the Doctors of CCAH about the progress, condition, treatments, and time of release of my pet from CCAH will be the sole duty of the pet owner. If different from pet owner's name listed above, please list one family member/contact person for CCAH to contact. _______________________

I further agree that in the case of non-payment, a finance charge of 1 1/2% per month (18 % per annum) will be charged and that any collection fees or attorney fees for collection will be paid by me.

I have read and fully understand the above document and agree to all of its conditions.

OWNER'S SIGNATURE: ____ DATE: ___________________

CCAH WITNESS TO SIGNATURE: ____________________________________ DATE: ___________________

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