PIKESVILLE ANIMAL HOSPITAL
1496 Reisterstown Road, Suite 111 ♦ Pikesville MD 21208
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Carey Zumpano, DVM Diplomate ABVP
Kristine Covert, DVM
Lisa Tinanoff, DVM

Authorization for Treatment

Date:

Procedure:

Client ID:	Patient ID:
Client Name:	Name:
Address:	Species:
	Breed:
	Sex:
Telephone:	Color:
Rabies Tag #	Markings:
Microchip #	Birth Date:

I, the undersigned owner, agent of the owner, 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 Pikesville Animal Hospital. 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 some unexpected life-saving emergency care be required and the attending veterinarian be 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 the costs 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 ongoing medical treatment. If this pet is hospitalized, I agree to pay a deposit of 50% of the estimated fees. I agree 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 form the hospital. In the event the pet is hospitalized for more than 48 hours and the attending doctor is unable to reach me, I understand it is my responsibility to call the hospital at least every 48 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 the unpaid balance.

I understand that veterinary care during nighttime hours and/or weekends is not provided at by Pikesville Animal Hospital. Continuous presence of personnel is not provided during these hours.

I agree that either 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/client record. I agree that if I fail to comply with this policy, the hospital may handle this abandonment in a manner that is in the best interest of the pet and the hospital.

____________________________________ ______________________
Signature of Owner or Authorized Agent Date

____ ______________________
Signature of Parent or Legal Guardian Date
(if owner/agent less than 18 years of age)

Phone number(s) at which you can be reached today and/or tomorrow. It is very important that we have at least one number where you can be reached.

Contact Number(s):

Please list all medications that your pet takes. INCLUDE medication name, dosage, and date/time given.

When is the last time your pet had anything to eat?

HAVE YOU TALKED WITH YOUR DOCTOR ABOUT THE FOLLOWING

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