

RELEASE FOR TREATMENT/MEDICAL RECORDS

I do hereby certify that I am the owner (or duly authorized agent of the owner) of this/these animal(s); that I hereby authorize the CARTERSVILLE ANIMAL HOSPITAL, their agents or representatives, to perform the medical or surgical procedures or other such treatments which the veterinarian deems necessary. I understand that to prevent the spread of infectious diseases and parasites, all hospitalized or boarded animals must be current on all vaccines, *given by a licensed veterinarian*, must be free of internal and external parasites according to this hospital's written policy. (If you have questions in regard to this hospital's vaccine and parasite protocols, please ask.) I authorize CARTERSVILLE ANIMAL HOSPITAL to provide examinations, vaccines and parasite control when needed; and I further agree to accept responsibility for the payment of all services rendered. I authorize the CARTERSVILLE ANIMAL HOSPITAL to obtain medical records for all my pet(s), from other veterinary hospitals for which my pet(s) has/have been treated. In the event that another veterinary hospital requests the medical records of one of my pets for routine or emergency care, I give the above named hospitals permission to release medical records of my pet(s).

Pet's Names:

I understand that continuous 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. If deemed appropriate, you may have the option to transfer your pet to a facility that can provide this service. Emergency after hours service for current clients is available by dialing 770-547-9153.

I further agree that I, or an authorized agent of mine, will pick up my pet five (5) days of receiving notification of discharged. I understand and agree that I will pay for all accrued charges at the time my pet is released. 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 interest of the pet and the hospital.

PAYMENT POLICY

Full payment is required at the time of service. *At your request*, our hospital staff will provide you with a written estimate for all hospitalized cases or other services recommended by the veterinarian. Deposits are required on medical/surgical cases, trauma cases, and emergency care; followed by full payment of the balance when your pet is released. We accept Cash, Visa, Mastercard, American Express, Discover, Care Credit. All credit card payments will require proper ID for verification. Personal checks will only be accepted with proper ID and drawn on a *local bank. No out of state checks will be accepted as payment.* **If you are planning on writing a check, please plan on providing proper ID and see receptionist for a Check Verification Form.**

I hereby state that I have read this RELEASE FOR TREATMENT AND MEDICAL RECORDS and that I understand the PAYMENT POLICY AGREEMENT.

DATE _____

SIGNATURE _____