

COMPANION PET CLINIC

211 NE Crestwood Court * Vancouver, WA 98684
360-254-8811

“AUTHORIZATION FOR MEDICAL AND / OR SURGICAL TREATMENT

1. I, the undersigned, owner or agent of admitted patient, hereby authorize **Drs. Giffoni, Clemetson, Price, Johansen, Levinson,** (and whomever s/he may designate as assistants) to administer such treatment(s) as is necessary, and to perform the following surgical procedure(s):

And such additional procedures as are considered therapeutically and/or diagnostically necessary on the basis of findings during the course of a physical evaluation. The treatment/s or procedure/s is/are to include whatever is necessary to accomplish the purpose, including but not limited to the administration of drugs and anesthetics. I, there fore, consent to the administration of such drugs and anesthetics as are necessary.

2. Anesthetic Risk:

I understand that all anesthetics present some risk of complications and serious possible damage to vital organs and that in some cases may result in paralysis, cardiac arrest and/or brain damage, or death, from both known or unknown causes.

3. It is understood that all services will be rendered in accordance with the modern standards of veterinary practice and that the Doctor(s) are released from liability for complications which may arise during medical or surgical care and hospitalization of my pet.

4. I understand that Companion Pet Clinic and its doctors reserve the right to treat any complications and/or problems

that may arise from the surgical procedure or medical treatment performed on my pet. **I understand and agree that Companion Pet Clinic will not be responsible for charges incurred at any other veterinary facility** should I elect to have my pet treated for complications elsewhere.

5. If for any reasons the agreed fees are changed due to complications. I agree to pay such charges if contacted by telephone. In case such contact is impossible or infeasible, I agree to pay charges only if my pet's life was in jeopardy.

6. I hereby certify that I have read and fully understand the above **Authorization for medical and/or surgical Treatment**, the reasons why the above named surgical procedure(s) is/are considered necessary and its alternative modes of treatment which were explained to me by **Drs. Giffoni, Clemetson, Price, Johansen, Levinson** I recognize that every conceivable **hazard** and **complication** cannot practically be mentioned or discussed. I acknowledge that no guarantees or assurances have been made to me concerning the results of this (these) treatment(s) and/or procedure(s). **Not with-standing the risk**, I request this (these) treatment(s) and/or procedures(s) and waive any and all claims of damages against Companion Pet Clinic, its doctors, officers and employees in the event of complications, injury or death of my animal. I further understand that this agreement shall be effective for any and all subsequent admissions to Companion Pet Clinic.

7. I agree to pick up my animal following surgery, as directed by the clinic, and understand that if I fail to comply I will be charged extra for board, and that my animal may be declared abandoned.

8. I hereby declare under penalty of perjury that I own the animal described below or am authorized to present it for the indicated surgery and/or treatment.

9. I agree to hold harmless and indemnify **Companion Pet clinic**, its officers and employees from any loss, injury or damages arising out of or in connection with services requested by me herein.

10. I hereby authorize **Companion Pet Clinic**, in the manner it routinely follows, to perform the above-mentioned treatment(s) or procedure(s). **I also assume financial responsibility for all charges incurred to the patient, and agree to pay all charges at the time the services are rendered.**

11. Should charges not be paid when due, I promise to pay in addition all costs of collection and reasonable attorney's fees, whether or not suit is filed upon. All delinquent accounts bear interest at the legal rate.

12. I understand that Companion Pet Clinic does not provide in-house, on-duty continuous medical staff care overnight, on weekends after closing or on holidays.

13. I certify that I have read the foregoing and agree to all the terms and that I understand all that I have read and have had explained to me.

Owner or Party Assuming Responsibility _____ **Date** _____

Pets Name _____ **Phone Number** (_____) _____