



PILCHUCK VETERINARY HOSPITAL HOSPITAL ADMISSION AGREEMENT

I, the undersigned, do hereby certify that I am the owner (or duly authorized agent of the owner) of the animal identified herein and that I do hereby authorize the above identified veterinary hospital, their agents and/or representatives, to perform the surgical and/or medical procedures, to administer anesthesia, x-ray examination, drugs and/or medications and/or to perform other diagnosis and/or treatment which the attending veterinarian deems necessary.

I further authorize the performance of procedures and/or administration of drugs and/or medications which are in addition to or different from those now contemplated and/or those which may have been explained to me, if unforeseen conditions arise in the course of treatment of operation and such additional and/or different procedures and/or medications or drugs are judged necessary by the attending veterinarian.

I further certify that the nature and purpose of contemplated procedures, identifiable alternative methods of treatment, risks involved and possibility of complications, have been explained to me and are understood by me, and that I recognize no guarantees or assurances have been given me as to results which may be achieved.

PAYMENT POLICY (HAS BEEN DISCUSSED WITH CLIENT BY _____ (INITIALS))

- I (the owner or duly authorized agent thereof) agree to accept responsibility for full payment of all treatment and services rendered by Pilchuck Veterinary Hospital. I do understand this is just an estimate and not the final bill.
- **I agree to pay a deposit of at least 50% of the estimated charges when the animal is admitted to the hospital. I further agree to pay the balance of the fees due before the release of the animal from the hospital.**
- If it is necessary to bring an action to compel the payment of fees or costs, the undersigned shall pay all costs incurred in collection of the debt and reasonable attorney fees. If suit is initiated to enforce the terms of this agreement, the courts of the State of Washington shall have personal jurisdiction over each of the undersigned makers and the venue of the suit, at the option of the holder of this agreement, may be in Snohomish County, Washington.

VISITING/DISCHARGE POLICY

- I understand that I may be able to visit my animal while hospitalized between the hours of 9:00 AM to 6:00 PM, Mon-Fri, 9:00 AM to 5:00 PM Sat, or by other arrangement with the doctor.
- **I understand that no animals will be discharged from the hospital without prior arrangement.**
- I understand that the hospitalization fees are a minimum of \$65.00 per day.
- I hereby state that I have read and understood this authorization and release and acknowledge receipt of a copy thereof.
- If signing as agent of the owner, the undersigned warrants that he/she has authority to bond the owner.

Owner: _____ Date: _____

Agent: _____

Patient: _____

Estimating Doctor: _____ Dr. Conrad Boulton _____ Dr. Joanne Fehr _____ Dr. Laura Hradec
_____ Dr. Lisa Krauter _____ Dr. Jim Bryant _____ Dr. Roger Hancock

Estimate of charges \$ _____ 50% of estimated charges paid \$ _____

I will be paying by: Cash _____ Check _____ Bank Card acct # _____