

MEDICAL ACCOMMODATION RELEASE FORM

Monument East Veterinary Hospital

(520) 298-8358

Owner: _____

Date: _____

Patient: _____

Accommodation from _____ to _____

Diet: _____ Quantity Fed: _____

Meal Time: AM NOON PM FREE FEED

Special Meal Instructions: _____

MEDICATIONS: _____

Belongings: _____

Comments: _____

While here, I would like _____ evaluated for the following problem(s):

I would like the following procedures performed. (This will be added to your estimate.)

Nail trim____ Teeth scaling____ Anal sacs expression____ Ear cleaning____ Microchip____

EMERGENCY CONTACT INFORMATION:

Authorized Agent(s) as listed below:

(1) _____ Contact Number: _____

(2) _____ Contact Number: _____

In the event of an emergency or due to an apparent or latent medical condition, I authorize all life saving measures or any necessary treatment to be performed at the Doctor's discretion, understanding all attempts will be made to contact me. I further understand that if my pet is found to have external parasites (fleas, ticks, etc) upon entering the hospital, my pet will be treated and the parasite control will be added to my bill.

Please sign below and provide us with an emergency phone number. In case an emergency occurs when I, the owner, cannot be reached, I authorize the above-named agent(s) to request emergency services from Monument East Veterinary Hospital for the above specified animal(s) or any other animals I may own at that time. I agree to pay for such veterinary care, not to exceed \$ _____, within a thirty-day period. If the bill for such services is not paid within this time period it may be billed to my credit card # _____ Expiration

Date: _____

Signature of owner: _____ **Date:** _____

NOTE: THIS HOSPITAL DOES NOT HAVE OVERNIGHT CARE OR 24 HOUR SUPERVISION OF PATIENTS. PLEASE INITIAL _____