

Noah's Friends Inc.
Authorization Form for Exam, Surgery,
Treatment or Drop-Off

Client Name: _____		Pet Name: _____			
Species	Sex	Altered	Breed	Color	Age
Surgery or Anesthesia: _____					Date of visit: _____
Reason for being seen: _____					

Please Initial each line:

_____ This office promotes a flea and tick free environment. If fleas and/or ticks are found on your pet, a preventive product will be applied and you will be responsible for payment.

_____ Proof of rabies vaccination MUST be on file with us. If the vaccination certificate is over 1 (one) year from today's date, a rabies vaccine (or update, if applicable) will be given.

_____ A deposit equal to a routine office visit may be required. This deposit will be applied to your total charges. If an estimate of charges was given, I understand that it is an approximation of planned procedures and the final bill may be more or less than this amount.

_____ I authorize Noah's Friends Inc. to perform such diagnostic, therapeutic and surgical procedures as described above, including vaccinations, medications, anesthetics and treatments which the doctors deem advisable or necessary for the health, safety or well-being of this animal while it is under their care and supervision. The nature of such services has been described to my satisfaction. I realize that there are risks involved with any anesthetic or surgical procedure, including complications, injury or even death and that no guarantee or warranty can be made regarding the results or cure.

_____ I authorize Noah's Friends Inc., in an emergency situation, to provide life-saving procedures as needed for the well-being of my pet for an amount of time as determined reasonable by the doctor. Only those pets who are of a certain age and/or health condition AND whose owner/agent has discussed with the doctor their wish to not prolong any suffering of their pet may sign for a DNR (Do Not Resuscitate).

DNR _____ (owner/agent) _____ (doctor)

_____ Noah's Friends Inc. is NOT staffed 24 hours a day. Pets in stable condition will be left unattended overnight. However, if something unforeseen happens, no one will be on hand to help. If my pet requires intensive care during the hours when the hospital is closed, or if I prefer constant supervision for my pet, I understand that I will have to make arrangements to pick him/her up and take him/her to a hospital with overnight and/or weekend supervision.

_____ My charges, including boarding costs, shall be paid upon release from the hospital. If the pet is not picked up within 3 days after the time specified for return, and if the doctor is not notified in writing of an alternate date within the 3-day period, the animal will be considered abandoned and may be disposed of as the doctor sees fit. It is understood that this does not relieve me from paying for all costs of your services and use of your hospital including the cost of boarding.

_____ I understand that I assume financial responsibility for all services rendered. If payment is not given in a timely manner, the account may be turned over to collections and I will be held liable for all attorney and collection fees, court costs and cost of litigation.

Signature of Owner or authorized Agent/Today's Date

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Phone # for today