Hospitalization Information/Consent

DATE:_____

Please complete the following information form front and back. Please print.

OWNER INFORMATION

NAME:_____

MAILING ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

COUNTY:_____CELL PHONE:_____ALT PHONE:_____

Email address:_____

CREDIT CARD #:_____EXP DATE:_____CVC:_____

NAME AS IT APPEARS ON CARD:_____

Driver's license / social security number:_____

PATIENT'S NAME:_____BREED:_____SEX:_____

AGE:_____COLOR:_____IN FOAL?_____INSURED:_____

COMPANY NAME:_____PHONE:_____

REFERRAL VETERINARIAN:_____PHONE:_____

ESTIMATE OF SERVICES:

Treatment for this animal is estimated to be from _____to _____. **PLEASE NOTE THAT THIS IS ONLY AN ESTIMATE. THE FINAL CHARGES COULD BE EITHER HIGHER OR DEPENDING ON THE STATUS OF THE ANIMAL.**

PLEASE READ AND COMPLETE THE BACK OF THIS SHEET

PLEASE INITIAL EACH STATEMENT BELOW.

1. I am owner or authorized agent of the animal described on the previous page, and authorize testing/treatment/surgery by Summit Equine Hospital._____
2. Some procedures are inherently risky and complications may arise despite all efforts to prevent them. I have been informed of the risks and complications associated with my animal's disease, planned procedures, and any potential treatment. I realize that results cannot be guaranteed._____
3. Anesthesia and sedation depress the function of the brain, heart, and other vital organs. Debilitated or critically ill animals are most at risk while sedated or anesthetized. I give permission to sedate and/or anesthetize my animal as needed to allow testing/treatment/surgery._____
4. I have had the opportunity to ask about alternatives to the suggested procedures/treatments/surgery. _____
5. I am aware that the estimate for my animal's surgery/hospitalization is _____. I am aware that as more is learned about my animal's problem, **additional costs may arise**. I understand that Summit Equine Hospital will make every effort to contact me daily about the current charges. If I do not receive an update on current charges each day, I agree to contact Summit Equine Hospital. _____
6. I assume full financial responsibility for all charges due for diagnostic procedures/treatments/surgery done at Summit Equine Hospital. I am also aware that unforeseen events resulting from diagnostics/treatment/surgery, will not relieve me from any obligation to all reasonable costs incurred during hospitalization/surgery._____
7. **I am leaving a deposit of $500.00.** I understand that additional deposits may be required and that **the balance is due in full** when my animal leaves the hospital._____
8. **(Please initial one option.)** If an emergency arises and I cannot be contacted, I give authorization to the clinicians of Summit Equine to treat my animal using their best judgment._____; **OR** Summit Equine should not provide additional emergency treatment._____
9. If an emergency arises and I cannot be contacted, I give authorization to the clinicians of Summit Equine to humanely euthanize my animal to prevent unnecessary pain and suffering._____
10. I can be reached 24 hours a day, 7 days a week and/or have voice mail at the following phone number: _____.
11. I understand and agree to pay interest charges that will accrue at an annual percentage rate of 18% (APR) should any balance remain unpaid on the account after my animal's release from the hospital._____

I have read and understand the above statements:

_____**(Signature)**

_____ **(Printed name)**

_____ **(Date)**