

The following information is necessary in order that we might serve you better and give you more personal attention. **Please fill out the form completely.**

AUTHORIZATION FOR PROFESSIONAL SERVICES

OWNER _____ PET'S NAME _____

ADDRESS _____ BREED _____

CITY _____ STATE _____ ZIP _____ SEX _____

TELEPHONE NUMBER DAYTIME (____) ____ - ____ EVENING (____) ____ - ____

I hereby authorize performance of the following procedures:

Your pet may be walked before or after its procedure.

The nature of such service has been described to me to my satisfaction and I realize that no guarantee or warranty can ethically or professionally be made regarding the results or cure.

I understand that I assume financial responsibility for all services rendered, and that payment is due on the date of surgery.

I also understand a flea and tick treatment is required. If evidence of live fleas or ticks are found on my pet, a topical flea treatment will be applied.

SIGNED _____
(Owner or Agent of Owner)

DATE _____

Discharge Hours: 4:00pm – 6:00pm