

North Georgia Veterinary Hospital, P.C.
Ocoee Animal Hospital
88 All Creatures Place •Blue Ridge, GA 30513

TREATMENT RELEASE FORM

Owner's Name: _____

Pet's Name: _____

Doctor (if specified): _____

I authorize North Georgia Veterinary Service / Ocoee Animal Hospital to perform the following medical and /or surgical procedures for the purpose of diagnosis and treatment of my pet.

I also authorize the use of appropriate anesthesia or sedation and I understand that hospital support personnel will be employed as deemed necessary by the veterinarian. I understand that during the performance of the service, unforeseen conditions may be revealed that necessitate an extension of the services, or different services than those listed above. Therefore, I hereby consent to and authorize the performance of such services as are necessary in the exercise of the veterinarian. All animals entering the hospital must be current on vaccinations and free of external parasites or they will be treated at the owner's expense.

I agree to pick up my pet within five (5) days of the discharge date or my pet will be considered to be abandoned. In the event of abandonment, the hospital is authorized to dispose of my pet deemed professionally necessary. Pets are released only during regular office hours.

I understand that with virtually all surgeries, and with some medical or diagnostic procedures, pain medications will be administered and/ or dispensed and charged for unless declined.

I would like pain medication for my pet Yes___ No___

I have been advised as to the nature of the services to be performed and the risks involved and realize that results cannot be guaranteed. I also understand that I am financially responsible to North Georgia Veterinary Service, P.C. / Ocoee Animal Hospital for all applicable charges related to the services performed regardless of outcome. Full payment is due upon release of the pet

I have read and understand this authorization and consent. I agree to the payment method indicated.

Cash _____ Check_____ MasterCard/VISA/Amex/Discover_____ Care Credit_____

Owner/Agent Name: _____

(Please Print)

Owner/Agent Signature: _____

Date In: _____ Date Out: _____

Telephone Number(s) where **owner** can be reached: _____
