



912 W. Williams St.
Apex, NC 27502
(919) 267-9315

Drop Off Authorization for Care

Pet's Name: _____ Date: _____ Reason for Visit: _____

Please list the name and phone number of the person who is responsible for making medical and financial decisions and can be reached immediately while your pet is with us today.

Name : _____ Phone Number(s): _____

Date & Time Your Pet Last Ate: _____

Personal items left with pet today: _____

Do you have a time you must pick-up by? (Please circle) YES NO If so, what time? _____

- During today's visit, the doctor may discover necessary diagnostic(s) and/or treatment(s) my pet would benefit from. I authorize the doctor to do so without contacting me first as long as the additional invoice total does not exceed \$_____.
Please check any of the following additional services you would like us to perform today:
Microchipping \$64.12 Ear hair plucking/removal \$18.61
Anal sac expression \$29.24 Ear cleaning/wax removal \$32.62
Nail grinding (dogs only) \$39.37 Nail trim \$19.59 (no charge with anesthesia)
Other: _____
FOR DENTALS ONLY: During the dental, if the doctor finds teeth that need to be removed, I authorize removal of those teeth without contacting me first up to the additional invoice total listed above. (Please circle) YES NO
DOG OWNERS ONLY: I authorize All 4 Paws Animal Hospital to walk my pet outdoors on a leash (Please circle) YES NO

I, the undersigned, am the owner or authorized agent of the owner of the pet named above, and have the authority to consent to medical procedures. I authorize All 4 Paws Animal Hospital to obtain all medical records regarding my pet from all other hospitals where my pet has been treated or examined and to release all medical records regarding my pet to any other hospital. I understand that All 4 Paws Animal Hospital will exercise every reasonable precaution to ensure the safety of my pet while in their care but there is a risk of complication(s) with any medical procedure, treatment, vaccination, surgery or anesthesia including the possibility of death. The nature and risks of such complications have been explained to me and any questions have be answered so I authorize and direct the veterinarians or associates of All 4 Paws Animal Hospital to perform the agreed upon procedures, treatments, etc. I understand that there is no guarantee, nor can one be made as to the results of any therapy. In order to prevent the spread of infectious disease, I authorize All 4 Paws Animal Hospital to administer a Rabies vaccine, and/or flea or tick medication to my pet, at my expense, if needed. I understand that if my pet has an infectious disease that requires my pet to be housed in the isolation ward, or if my pet stays overnight, I will be charged a hospitalization fee. I agree to pay, in full, for services rendered. I understand that payment is due and expected on the day service is rendered. If I neglect to pick up my pet within ten (10) days of the date above, All 4 Paws Animal Hospital is to assume that my pet has been abandoned and is authorized to make arrangements for the pet's care as they deems necessary.

Signature

Printed Name