



CANYON PET HOSPITAL

NORTHERN ARIZONA'S PREMIER VETERINARY HOSPITAL

DROP OFF

Date: _____ Client: _____ Patient: _____

Once the examination is complete, a doctor will call you to communicate what steps need to be taken and an estimate of cost. **We will not continue treatment until we speak with you; therefore it is extremely important that you are available to be reached by phone at any given time.** Please leave two phone numbers and the best time you can be reached at those numbers.

Phone number: _____ Best time to call this number: _____

Phone number: _____ Best time to call this number: _____

If the total cost of treatment does not exceed \$ _____ you may continue with treatment, otherwise please call.

I hereby authorize the staff at Canyon Pet Hospital to examine, prescribe for and/or treat my pet and will assume all financial responsibility incurred in the care of my pet. I also understand that I will be responsible for payment of services agreed upon by myself after communication with the doctor and that payment must be made in full at the time I pick up my pet. I understand that a deposit may be required if my pet is hospitalized and that trained personnel may not be attending to my pet beyond regular office hours unless deemed necessary by the veterinarian. I understand that if my pet requires anesthesia, the doctors and staff will use all reasonable precautions against injury, escape or death of my pet. I understand that all anesthesia involves some minimal risk to my pet and I will not hold the doctors and staff at Canyon Pet Hospital responsible under any circumstances.

Signature: _____ Date: _____

Canyon Pet Hospital accepts cash, Visa, MasterCard, Discover, Care Credit and checks with Telecheck approval. If you are going to be writing a check please be aware of the following policy. We do not accept counter or post dated checks. We will not hold checks for any period of time. We require a valid drivers license when accepting a check. A \$30 fee will be assessed for all returned checks.

FOR HOSPITAL USE ONLY

Detailed history of problem including symptoms and how long symptoms have been going on:

Estimate for treatment \$ _____ Estimate reviewed with owner (initial) _____