



## Atlanta Animal Hospital

Atlanta Animal Hospital

Dr Reddy, DVM

Dr Sharmila, DVM

785 Peachtree Pkwy

Cumming, GA 30041

P: 678-807-7824

F: 678-807-8236

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Owner's Name: \_\_\_\_\_ Pet's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I am the owner (or authorized agent for) of the above-mentioned animal.

I have discussed the reasons for hospitalization with the doctors of Atlanta Animal Hospital and I am satisfied with the plan of management. The nature of such services has been described to me to my satisfaction and I realize that neither guarantee nor warranty can ethically or professionally be made regarding the results or cure. I authorize use of sedatives and pain medications if deemed warranted by the doctor in charge of the case. If anesthesia or sedation is required, I understand and accept that there are always inherent risks, including death. I also authorize the clinic staff, in an emergency situation, to follow through with such procedures as are necessary for the well-being of my pet on a continuing basis until further communication with me is possible.

While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no guarantee or warranty has been made regarding the results that may be achieved. I agree to assume financial responsibility for the remaining fees, and provide payment via cash, credit card, or check at the time my pet is discharged from the hospital. Should unexpected life-saving emergency care be required and the hospital staff is unable to reach me, the staff has my permission to provide such treatment and I agree to pay for such services.

I understand that during the performance of medical, surgical, or anesthetic procedures, unforeseen conditions may be revealed that necessitate more extensive, costly, or different procedures than originally planned. If staff at this veterinary practice are unable to reach me, I hereby consent to and authorize the performance of such procedures as are necessary and desirable in the professional judgment of the attending veterinarian.

I have also had the likely fees explained to me and I have received my estimate of \$\_\_\_\_\_ for anticipated medical services. It is understood that there may be unforeseen complications and that

further treatment may be necessary during the hospitalization. I accept and assume full and total financial responsibility for any and all services rendered by the clinic, its staff or employees in the treatment of the above described animal and agree to pay the fees at the time of my pet's discharge or other demise.

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Signature

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Date

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Phone Number