All Pets Veterinary Hospital, LLC
Low-Cost Surgery Registration Form

Authorization for Anesthetic Procedure(s) and/or Surgery

Client's Name ____ Pet's Name ________________________________

Species__________________________________ Sex: M CM F SF U

Anesthetic and medical or surgical procedure(s) to be performed: ____Spay Or Neuter___________

I, the undersigned owner or agent of the owner of the pet identified above, certify that **I am / I am not (circle one)** eighteen years of age or older and authorize the Doctor to perform the above procedure(s). I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the Doctor before the procedure(s) is/are initiated. My signature on this form indicates that any questions I have regarding the following issues have been answered to my satisfaction:

- The reasonable medical and/or surgical treatment options for my pet
- Sufficient details of the procedures to understand what will be performed
- How fully my pet will recover and how long it will take
- The most common and serious complications
- The length and type of follow-up care and home restraint required
- The estimate of the fees for all services
- Any necessary payment arrangements

While I accept that all procedures will be performed to the best of the abilities of the Doctor and the staff at this hospital, I understand that veterinary medicine is not an exact science and that no guarantee or warranty has been made regarding the results that may be achieved Should unexpected life-saving emergency care be required and the hospital staff is unable to reach me, the staff:
(circle one) a) does have b) does not have
my permission to provide such treatment and I agree to pay for such services. I understand that an estimate of the fees for the above procedures will be provided to me and that I am encouraged to discuss all fees related to such care before services are rendered. I agree to pay and assume financial responsibility for the balance of services rendered, and agree to provide payment of cash or credit card at the time my pet is discharged. In the event of an open balance, I agree to pay a monthly payment and financing fee equal to 1.5% of the unpaid balance.
In the event my pet is hospitalized beyond the first day at this facility, I understand that veterinary care during nighttime hours and/or weekends is provided at the discretion of the Doctor. Continuous presence of personnel may not be provided during these hours. If my pet needs overnight hospitalization and I **do not** want to have my pet hospitalized when this facility is closed and no veterinary staff are present to supervise in the facility, I elect to:
(circle one)
a) pick up my pet and provide such care in my home, in which case I accept all risks of adverse effects

b) have him/her transferred to a local emergency clinic where overnight veterinary supervision is available at my expense

I accept that veterinary medicine is an inexact science and that no guarantee of successful treatment has been made. I have read and understand the nature of the above procedures and give my consent to proceed.

____ ________________________
Signature of Owner or Authorized Agent Date

____ ________________________
Signature of Parent or Legal Guardian Date
(if owner/agent less than 18 years of age)

(_____) _____-____________ (_____) _____-__________
Phone number(s) where I can be reached on the day of surgery

All Pets Veterinary Hospital, LLC
24 Ferry Road Nashua, NH 03064
603 882-0494