

# PRINCETON VETERINARY ASSOCIATES

Please print, complete and bring this form with you at the time of your pet's appointment.

Princeton Animal Hospital  
(609) 520-2000

Carnegie Cat Clinic  
(609) 951-0400

Plainsboro W. Windsor Vet. Hosp.  
(609) 799-3110

## AUTHORIZATION FOR PROFESSIONAL SERVICES

OWNER \_\_\_\_\_ PET'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ BREED \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SEX \_\_\_\_\_

FIRST # TO REACH CLIENT AT \_\_\_\_\_ 2<sup>ND</sup># \_\_\_\_\_ 3<sup>RD</sup># \_\_\_\_\_

Person we are contacting \_\_\_\_\_

AN ESTIMATED RANGE OF COSTS FOR THIS PROCEDURE IS: \_\_\_\_\_

I hereby authorize performance of the following procedure(s) :  
\_\_\_\_\_

Add. Work: \_\_\_\_\_ Client: \_\_\_\_\_ Amt: \_\_\_\_\_ Date: \_\_\_\_\_

The nature of such service has been described to me to my satisfaction and I realize that no guarantee nor warranty can ethically or professionally be made regarding the results or cure.

I understand that during the performance of the foregoing procedure(s), unforeseen conditions may be revealed that necessitate an extension of the foregoing procedure(s) or different procedure(s) than those set forth above.

Therefore, I hereby consent and authorize the following:

\_\_\_\_\_ I authorize the above work only.  
ANY additional immediate work must be cleared by me before action can be taken. I understand that the immediacy of necessary action during an anesthetic procedure. I realized that if I am unable to be contacted, **I do not give permission for any additional procedures, INCLUDING LIFE SAVING MEASURES.**

\_\_\_\_\_ If I am unable to be contacted, I yield to your best judgment.  
Please make every effort to maintain my pets health. I am aware of the general cost associated with the above procedure(s), however, **ADDITIONAL** veterinary costs are an important consideration for me. Please notified me if costs will **EXCEED THE ALREADY "AURHORIZED" WORK BY:**

\_\_\_\_\_ \$1.00 - \$50.00 \_\_\_\_\_ \$51.00 - \$100.00

\_\_\_\_\_ \$101.00 - \$200.00 \_\_\_\_\_ not necessary

\_\_\_\_\_ Please keep me posted as to the cost of additional procedures.

\_\_\_\_\_ Please keep me posted daily regarding my current balance.

\_\_\_\_\_ It is not necessary to be told daily of the day to day charges.

I understand that I assume financial responsibility for all services rendered, and full payment is due on the date of service.

OWNER OR AGENT OF OWNER: \_\_\_\_\_ DATE: \_\_\_\_\_

Estimates checked by Doctor = \_\_\_\_\_ Estimate reviewed with \_\_\_\_\_