



Hospitalization Information and Consent

Please complete **both** sides of form. Print clearly and initial where indicated.

Owner Information:

Name: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Social Security #:/Driver's License #: _____

Phone Number(s): _____

Trainer/Agent: _____ Phone Number(s): _____

Credit Card: Visa _____ MasterCard _____ American Express _____ Discover _____ Care Credit _____

Credit Card #: _____ Expiration Date: _____ SVC# (back of card/front on AE): _____

Print name as it appears on card: _____

Signature: _____ Date: _____

(Note: Signing form authorizes Summit Equine Hospital to run card for account balance upon patient discharge.)

Patient Information:

Name: _____ Nickname: _____

Species/Breed: _____ Sex: _____ Age/DOB: _____ Color: _____ In Foal: Yes / No

Insured: Yes / No Company: _____ Phone #: _____

Referral Veterinarian: _____ Phone #: _____

Estimate of Services:

Treatment for this animal is estimated to be from _____ to _____.

(Note: This is only an estimate. The final charges may vary depending on the status of the patient.)

Please initial each statement below:

1. I am the owner or authorized agent of the animal described on page 1 and authorize testing/treatment/surgery by Summit Equine Hospital (SEH). _____
2. Some procedures, including sedation and anesthesia, are inherently risky and complications may arise despite efforts to prevent them. I have been informed of the risks and complications associated with my animal's disease, planned procedures, and any potential treatment. I give permission to sedate/anesthetize my animal as needed for diagnostics/treatment/surgery. _____
3. Please initial one: If an emergency arises and I cannot be contacted, I authorize the clinicians of SEH to treat my animal using their best judgement, including euthanasia if warranted to prevent unnecessary pain and suffering. _____ OR The clinicians of SEH should not provide additional emergency treatment. _____
4. I assume full financial responsibility for all charges due for diagnostic procedures/treatments/surgery performed by SEH. I am also aware that unforeseen events resulting from these actions may cause increases in cost and will not relieve me from any obligation for all reasonable costs incurred during hospitalization/surgery. I understand that SEH will make every effort to contact me daily about the current status of my animal as well as accumulated charges. _____
5. I am leaving a deposit of _____. I understand that additional deposits may be required and that the balance must be paid in full when my animal is discharged. I understand that I am responsible for any interest charges accrued thereafter. _____

I have read and understand statements 1 thru 5 listed above.

Signature: _____

Printed Name: _____

Date: _____

Emergency Contact Information:

Name: _____

Phone Number(s): _____

