Goodland Veterinary Services
7126 Hollister Avenue Goleta,
CA 93117
(805) 685-4513

Hospitalization Release Form

Client:_____Pet:_____
Address:_____Species:_____
_____Email: _____
Address:_____
Phone:_____Emergency/Cell:_____

EXTREMELY IMPORTANT THAT YOU GIVE US ALL PHONE NUMBERS THAT YOU CAN BE REACHED AT ALL TIMES TODAY !

Please list phone numbers in order of most important to least important:_____

I hereby consent and authorize the doctors and staff of Goodland Veterinary Services to receive, prescribe for, treat and/or operate on the above mentioned animal. The procedures to which I am currently giving my authorization for are as follows.
Check and Initial:
Physical Examination _____ Vaccination(s) _____ Diagnostics (Body Fluid or Other Tests) _____
Anesthesia/Sedation ____ Surgery _____ Medical Therapy ____ Hospitalization ____
Boarding ____ Dental Cleaning with Extractions as needed ____ Radiographs (X-Rays)/ Ultrasound ____
Critical Care ____ Other ____ Explain: _____

If this animal should injure itself in an escape attempt, refuse food, soil itself, become ill or die while in the hospital, I will hold the Goodland Veterinary Services, its Doctors and staff, free of any responsibility and/or liability in the absence of gross negligence. If I neglect to pick up the animal, within five (5) days of written notice that the animal is ready for release and mailed to the address which is filed with the hospital, the hospital may assume that the pet is abandoned. Goodland Veterinary Services is then authorized to dispose of the animal as they see fit. Abandonment does not release me of my obligation for payment of services rendered or any additional charges which have accrued during this time. This facility is not staffed between 7pm to 8am Monday through Thursday and Saturday-Sunday as well as 5pm to 8am Fridays unless special arrangements are made. I understand that, and except in the case of an emergency, any treatment or diagnostics not indicated above will be authorized verbally by the owner or agent of the owner. I also understand that payment for services is due at the time services are rendered and a 50-100% deposit is required before any work can be initiated depending upon pets physical condition at time of examination. I understand that no patient will be discharged without payment in full in accordance with California State Law. I understand that further fees will accrue as the pet remains hospitalized until bill is paid in full. I further agree that in the event of non-payment of the

entire bill, a finance charge of 2.0% per month (24% per year) will be applied to my account and that any collection fees or attorney fees incurred by this hospital will also be paid by me. I further understand that any estimate given is just an estimate and may vary depending on my pets health condition and medical or surgical needs at the time all work is being performed. I further understand that all inventory sales are final and no inventory may be returned as per state pharmacy laws. Furthermore all service deposits are final, however if we fail to use your entire deposit for any reason, the remainder of your deposit may be applied to your account for future use. If your credit is not used within 12 months of the deposit you will forfeit this credit. I have read the foregoing and agree to the above terms.

Signature_____ Date_____