Grand Traverse Veterinary Hospital

3805 Veterans Drive
Traverse City, MI 49684
(231) 946-3770
info@gtveterinary.com

Please list ANY and ALL adults (18 years or older) that you would like to be authorized to make decisions on your account. Please complete form in its entirety.

Owner Name: _____ Primary Phone Number:_____

Preferred Pronouns of Owner: _____ Pet Name(s):_____

Secondary Owner Name: _____ Primary Email Address:_____

Secondary Client Preferred Pronouns:_____ Secondary Phone Number:_____

Client Home Street Address, City, State and Zip Code: _____

_____

_____

Additional Authorized Agents(Pet sitter/Family Members authorized to make decisions on your behalf):_____

_____

_____

Notification Settings - We use text messages and email to communicate appointment reminders, as well as your pet's health reminders (vaccines, exams, etc), and occasional emergency closure notices. If you would like to opt OUT of these reminders, you will have the option to elect this at the time of receipt. If you elect to opt OUT of these reminders, you will NOT get appointment reminders and will be responsible to keep track of upcoming appointments and services due.

I, _____, the undersigned, am the owner or agent for the owner of the animal(s) described, and I have the full and exclusive authority to execute this consent.

PLEASE INITIAL THE FOLLOWING:

_____ I certify that I am 18 years of age or older.

_____ I give permission to doctors, staff, authorized agents, or representatives of this hospital to examine, prescribe for, and treat my pet(s).

_____ I agree to pay for all services rendered and medications, goods, and supplies at the time of visit or scheduled appointment.

_____ I understand that all fees are due at the time services are rendered and the hospital accepts cash, check, and all major credit cards.

_____ I understand that a deposit may be required for surgical or medical treatment.

_____ I release this hospital from any and all liabilities due to declined services, care, and treatments recommended by veterinarian.

_____ I understand that if I cancel an appointment under 24 hours, there will be a scheduling fee applied to the credit/debit card on file.

_____ I understand that if I am 10 minutes, or later, to my appointment rescheduling will be necessary.

_____ I give permission to release my pet(s) records to local emergency or specialty veterinary clinic for the purpose of diagnosis and treatment

By my signature below, I hereby acknowledge that I agree to all of the above and acknowledge the receipt of a copy of this agreement upon request.

Owner/Agent Name Date

_____ _____