

Owners Name: _____

Pet's Name: _____

Date: _____

I hereby authorize the performance of the following medical or surgical procedures:

I understand that before anesthesia, surgery, or diagnostic testing, it is sound medical procedure to perform some basic lab tests for the purpose of discovering any complications that could interfere with the safety of the surgery, anesthesia, or diagnostic testing (these tests may have already been done by us or your local vet). These tests include:

- Blood glucose (to measure blood sugar)
- BUN and Blood Creatinine (to measure kidney function)
- ALT and Blood SGPT (to measure liver function)
- Red Blood Cell Count (to check for anemia)
- Total Blood Protein

ADMITTING POLICY: In order to prevent the spread of contagious diseases, all patients admitted to our hospital must be current on vaccines and free of internal (worms) and external parasites (fleas & ticks). If your pet does not meet our admission requirements, he/she will be immunized and/or treated as necessary and a fee will be charged for the additional services not included in this fee estimate.

The nature of such services has been described to me to my satisfaction. I realize that neither a guarantee nor warranty can ethically or professionally be made regarding the results or cure. I understand that there is a risk when anesthesia is given to a pet. **I understand that I assume all financial responsibility for services rendered, and that full payment is due when the animal is released.**

WE ARE UNABLE TO KEEP ANY PERSONAL ITEMS FOR YOUR PET DURING THEIR STAY AS WE ARE TRYING TO MAINTAIN A STERILE ENVIRONMENT. ITEMS WILL BE DISPOSED OF IF THEY ARE ACCIDENTALLY LEFT IN OUR POSSESSION. IF YOU HAVE NOT RECEIVED ANY ITEMS BACK PLEASE REQUEST THEM PRIOR TO LEAVING YOUR PET IN OUR CARE.

Please list up to 3 of the best numbers to reach you while your pet is in our care:

(Please put in the order to be called)

1) _____

2) _____

3) _____

I have read and fully understand all the above terms regarding my pet.

Signature of owner or agent: _____

**OUR ESTIMATE FOR SERVICES IS
BETWEEN _____ AND _____.**

Payment terms: Payment is required when services are rendered. We accept all major credit cards.
A deposit of 50% of the estimated charges is required on patient admissions, and the balance is due when the patient is released.

(There is a \$30 return check fee payable to NORTHSTAR VETS on returned items)

PLEASE BE ADVISED THAT THIS FORM REPRESENTS AN ESTIMATE OF COSTS. THE ACTUAL AND FINAL BILL MAY BE LOWER OR HIGHER THAN THIS ESTIMATE. WE WILL MAKE EVERY ATTEMPT TO INFORM YOU AS WE APPROACH THE UPPER LIMIT OF THE ESTIMATE OR EXCEED IT. AT THAT POINT WE WILL REQUEST AN ADDITIONAL DEPOSIT. PLEASE DO NOT HESITATE TO ASK FOR AN ESTIMATE UPDATE AT ANYTIME DURING YOUR PET'S HOSPITALIZATION. BY PLACING MY INITIALS IN THIS BOX I HEREBY ACKNOWLEDGE MY UNDERSTANDING OF THIS STATEMENT.



AGREEMENT: I give permission to NORTHSTAR VETS to perform diagnostic, surgical and medical treatment as deemed advisable. It is understood that procedures of diagnosis, surgery and medical treatment will be discussed with me before proceeding, except in emergency circumstances. In many cases it is impossible to determine in advance the extent of surgical and/or medical treatment required, and I understand that the actual cost may exceed or be lower than the estimate given. I agree to make prompt and complete payment upon discharge of the above animal. I also understand that if I neglect to pick up the above animal within six (6) days of notification to the address I have given above, that said animal will be considered abandoned, as per the "New Jersey Unretrieved Animal Act" (copy available upon request), and that in doing so does not relieve me from my financial obligation. I further understand that in case of non-payment I will be subject to billing and finance charges of 1.5% per month on the outstanding balance on the account, plus 25% attorney fees.

Please note that this estimate is for today's procedure only and DOES NOT include any follow-up care (rechecks, x-rays, blood work, bandage changes, or procedures such as pin or implant removals or wound care).

Only the suture and/or drain removal is included in the estimate you are receiving today.

Signed: _____ Date: _____

Deposit: \$ _____

In the case that your pet were to suffer cardiac and/or pulmonary arrest (heart or breathing stops), do you authorize us to provide life-saving measures (i.e. cardiopulmonary resuscitation or "CPR")? CPR can include endotracheal intubation (placement of a breathing tube), administration of drugs, cardiac compressions (pushing on the chest), assisted breathing with oxygen supplementation, and/or defibrillation (electrical shocking of the heart). Cost of these services can be between \$400 to \$750 which is generally NOT reflected in your estimate. If you choose to allow these procedures for your pet, you will be contacted as soon as possible to be informed of the situation and given the options about how to proceed. In a critically ill patient, you may want to elect a do not resuscitate status or a "DNR". In a healthy pet undergoing an elective procedure, we would strongly recommend you allow full resuscitation. **Please initial your choice below.**

_____ **Yes**, I authorize appropriate life saving measures. I understand that if such measures are necessary that the cost of services may exceed my estimate
_____ **No**, I do not wish these life saving measures to be employed. At this time, I am electing for a "Do Not Resuscitate" status for my pet.