PET HEALTH BOARDING AGREEMENT

Owner's Name:_____

Pet's Name: _____ Phone#: _____

Date In : _____ Date Out: _____

EMERGENCY CONTACT NAME(s):

Primary Contact: _____ Phone#:_____

Secondary Contact:_____ Phone#:_____

Vaccination History (Please fill in date of last booster)

Canine	**Feline**
_____ DHPP(REQUIRED)	_____ FVRCP (REQUIRED)
_____ Leptospirosis (REQUIRED)	_____ Rabies (REQUIRED)
_____ Rabies (REQUIRED)	_____ Leukemia Vacc
_____ Intra Trac III or Bordetella (REQUIRED)	
_____ Lyme	

SPECIAL MEDICATION REQUIREMENTS: (Please note there is a fee per day to administer any medications to your pet)_____

_____

DROP OFF TIME/PICKING UP TIME POLICY

Boarding drop off time is no earlier than 9am, daily. Pick up time is no earlier than 9am, daily, and no later than 7:30pm Monday-Thursday, 5:30pm on Friday, 11:15am on Saturday. If you are picking your pet up earlier than planned, please call the hospital so we can get everything prepared for when you arrive. Boarding check in time will take approximately 20 minutes, please plan accordingly.

We ask that you not leave any toys, leashes, collars, & blankets here with your pet(s) as we cannot guarantee returning them to you.

HOSPITAL PAYMENT POLICY

We accept cash, checks, Mastercard, Visa, Discover, and Care Credit cards for payment of services. All payments are due at time the services are rendered, and we do not bill for any services. The balance will be paid in full, upon discharge, in the following manner:

( )Cash ( )Care Credit ( )Check (with proper ID) ( ) Discover ( ) Mastercard ( ) Visa

LATE CHARGES: In rare instances, charges for services rendered in the hospital may still be in the processing stages when you pick up your pet. The client agrees to pay for these services when a bill is received. It is also understood that if I do not pay this account as agreed, that a service charge of $5.00 per month will be charged, and that past due accounts are subject to costs of collection, including attorney's fees.

WAIVER

If my pet should refuse food, soil his/herself, injure his/herself in an escape attempt, become ill or die while boarding, I will hold the Cheektowaga Veterinary Hospital staff free of any responsibility and/or liability in the absence of gross negligence.

It is the intent of Cheektowaga Veterinary Hospital to return all personal items clean and in good condition. However, an individual pet's nature and circumstance beyond our control may prevent this. Therefore, all personal items left with pets are at the owner's risk, and may not be returned.

If I neglect to pick up my pet(s) within five (5) days after receiving written notice that he/she is ready for release, sent via registered mail to the address on file, you may assume that the animal is abandoned. You, Cheektowaga Veterinary Hospital, are under such circumstance then authorized to dispose of the animal as you see fit. I further realize that abandonment does not release me from any obligation to pay the entire bill in full.

AUTHORIZATION TO TREAT

I certify that I am the owner or the authorized agent of the owner of the above animal(s). I hereby consent and authorize the performance of the above procedure(s). **Furthermore, I give my permission to the Cheektowaga Veterinary Hospital staff , IN THE CASE OF AN EMGERGENCY** to administer and/or perform appropriate tests, procedure(s), medications (including anesthetics) and surgery that the veterinarian may deem necessary for the health, safety, and well being of the above animal while under their care and supervision.

If we are unable to notify the person(s) listed above, please indicate your wishes below should your pet require treatment to relieve immediate discomfort or to resolve an important medical condition that may occur while in the hospital's care:

_____ **Complete Care: Please perform whatever services the doctor deems necessary for the best care of my pet until someone can be reached**. I agree to be responsible for all charges related to this care.

_____**Intermediate Care (as noted below) for my pet until someone can be reached.**
_____ Medical care limited to supportive care only.
_____ Medical care limited to basic work-up and treatment only.
I authorize up to (check one): $150_____, $250_____, other amount $_____

_____ **DO NOT ADMINISTER any medical treatment until specific authorization is given.** I am aware that delay in treatment could cause irreversible conditions for my pet.

I agree to personally assume ALL risk to my pet(s) health and well being caused by these restrictions.

For the safety of all pets in our care, we require that all vaccinations are current. Parasites and fleas, if detected, will be treated at the pet owner's expense.

I have read and understand this authorization and consent.

SIGNATURE _____ DATE_____
(OWNER OR AUTHORIZED AGENT)