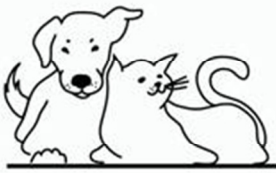

ASHLAND VETERINARY HOSPITAL, INC.

AAHA ACCREDITED The Standard of Veterinary Excellence

P.O. Box 205 • Ashland, Virginia 23005 • Tel.: (804) 798-8169 • Fax (804) 798-6533

Absent Owner Treatment Consent Form

Owner Name: _____

Doctor Preference (if available): _____

Patient(s): _____

Departure Date: _____ Return Date: _____

Contact Phone Number(s) while you are away: _____

_____

Name of person(s) taking care of pets during my absence: _____

_____

Phone Number(s): _____

Please check one of the following statements:

☐ The agent above will be able to make all decisions regarding veterinary care.

☐ I wish to be contacted for decisions regarding veterinary care. If I cannot be reached, I appoint the following person to act on my behalf:

Name _____

Phone _____

I understand that I am financially responsible for all services rendered by the doctors and staff of Ashland Veterinary Hospital and that payment is due on the date performed.

_____ _____

Client Signature Date

_____

Receptionist

_____

I authorize the use of my credit card number to be used only while I am away by Ashland Veterinary Hospital to pay for any medical expenses that my pet(s) may require. I am aware that my credit card number will be kept on file but will be stored in a private and confidential manner, and destroyed upon my return date.

I authorize the maximum of $ _____ to be used towards my pets' care at Ashland Veterinary Hospital.

☐ Visa ☐ Mastercard ☐ Discover

Number _____ Exp Date _____

Code _____ Name as it appears on the card _____

Cardholders Signature _____