HORIZON EQUINE Veterinary Clinic

1625 Angus Campbell Road
Abbotsford BC V3G 2G4
604-826-5089
care@horizonequine.ca

ADMISSION & AUTHORIZATION

In-Clinic Overnight Stay

CLIENT

Name | Phone | Cell

Address | Email

EMERGENCY CONTACT

Emergency contact name | Phone

Cell | Email

HORSE

Name | Age | Sex | Breed | Colour

Reason for admission

Current medications

Feeding instructions

CONSENT

Owner or authorized agent name

I am the owner, or agent for the owner, of the horse described above and have the authority to sign this consent. I consent to and authorize the following procedure(s) and/or operation(s):

Procedure(s) and/or operation(s)

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Please read, initial and sign below.

I certify that I own, or have assumed financial responsibility for, the horse described above, and I consent to and authorize Horizon Equine Veterinary Clinic Ltd. and its staff to hospitalize this horse and to give vaccinations, medications, tests, surgical procedures, anesthetics or other treatments the veterinarian deems necessary for its health, safety or well-being while under their care and supervision. I have been advised of the nature of the procedure(s) and/or operation(s) and informed of the associated risks. I understand that results cannot be guaranteed and that complications may occur despite the best efforts of the veterinarians and staff of Horizon Equine Veterinary Clinic Ltd.

Initials

If this horse becomes ill, is injured or dies while in the hospital, I will hold Horizon Equine Veterinary Clinic Ltd. and its staff free of all responsibility and liability. I understand that after-hours and weekend attendance of hospital patients is at the discretion of the veterinarian, and that a veterinarian may not always be on the premises.

Initials

I have read and understand this authorization and consent.

Owner/authorized agent name | Owner/authorized agent signature (Sign or draw here) | Date

Admitted and witnessed by (staff) | Date

TERMS OF PAYMENT

Please read the following and initial where applicable.

I am responsible for payment of the above procedures and treatments **in full at the time of discharge**, and the credit card listed below will be used to complete full payment owing.

Initials

Any previous veterinary visit or services at my "home" location are **not included** in this estimate and will be billed separately. This also applies to any visit that resulted directly in referral for in-clinic care at Horizon Equine Veterinary Clinic Ltd.

Initials

I agree to pay a 50% deposit of the estimate.

Initials

Card: ☐ Mastercard ☐ Visa ☐ AMEX

Estimate ($) | Card number | Expiry | CVV

Owner/authorized agent name | Owner/authorized agent signature (Sign or draw here) | Date

Admitted and witnessed by (staff) | Date