Please send the completed forms back to us at:
theanimalhospitaloflinden@gmail.com
Include a picture of your pet!

THE
ANIMAL HOSPITAL
of Linden

Welcome

Authorization To Provide Care

Owner's Name: _____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Home Phone: _____

Email:_____

Pet's Name:_____ Species (circle one): CANINE FELINE

Breed:_____ Color:_____ Sex:_____

Date of Birth or Age:_____ Spayed/Neutered (circle one): YES NO

I, _____, owner or authorized owner of _____,
hereby authorize and direct The Animal Hospital of Linden LLC
to perform the services deemed advisable and/or necessary for my pet.
This includes all procedures, treatments, and/or administration of extra label medications within accepted veterinary guidelines.
I understand that there is no guarantee, nor can one be made, as to the results or cure of any therapy.
I understand that payment is due at the time services are rendered.
If for any reason that payment is not made at the time services are rendered or within 10 days thereafter, I understand that my account may be referred to a collection agency.
In the event that my account is referred to a collection agency, I agree that The Animal Hospital of Linden LLC may add an amount to my outstanding balance to reimburse The Animal Hospital of Linden LLC for the reasonable collection charge (but not including attorney's fees) imposed by the collection agency.
I also understand that there are risks of a vaccine reaction with every vaccine that is given.
If there were to be a vaccine reaction, The Animal Hospital Of Linden LLC will not be responsible for the outcome of any vaccine reaction or any fees accrued for the treatment of a vaccine reaction from any other veterinary hospital at any time.
If a vaccine reaction were to occur, I understand that my pet needs to be brought to a veterinary hospital/emergency veterinary hospital immediately to seek treatment for the well being of the pet.

Signature:_____Date:_____