



**Broadway Veterinary Hospital**  
**Dr. Thomas P. Burgess**  
**117 S. Timber Way**  
**Broadway, VA 22815**  
**(540) 896-5155**

**Authorization for Anesthesia and/or Surgery**

Client Name: \_\_\_\_\_

Pet's Name: \_\_\_\_\_ Species: \_\_\_\_\_

Breed: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Anesthetic and surgical procedures(s) to be performed: \_\_\_\_\_

I, the undersigned owner or agent of the owner of the pet identified above, certify that I am eighteen years of age or over and authorize the veterinarian(s) at \_\_\_\_\_ to perform the above procedures(s). I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure(s) is/are initiated. My signature on this form indicates that any questions I have regarding the following issues have been answered to my satisfaction:

- The reasonable medical and/or surgical treatment options for my pet
- Sufficient details of the procedures to understand what will be performed
- How fully my pet will recover and how long it will take
- The most common and serious complications
- The length and type of follow-up care and home restraint required
- The estimate of the fees for all services
- Any necessary payment arrangements.

While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no guarantee or warranty has been made regarding the results that may be achieved. Should some unexpected life-saving emergency care be required, I give my permission to provide such treatment and I agree to pay for such service. I also agree to pay for any and all pain medication, flea treatment, and other services that ensure the safety and comfort of my animal and others in the hospital. I assume financial responsibility for the balance of all services on a cash, credit card, or check basis at the time pet is discharged from the hospital.

In consideration of services performed by \_\_\_\_\_, I hereby agree to pay all amounts owed to same. I also understand a FINANCE CHARGE is applied to all accounts unpaid after 30 days. The FINANCE CHARGE is computed by a periodic rate of 2% per month, which is an annual percentage rate of 24%. Minimum charge of \$1.00. In the event my account is turned over to an attorney for collection, I also agree to pay all court costs and attorney fees or \$25.00 whichever is greater. I understand and agree that in the event collection procedures are implemented against me, all procedures will be filed in the Rockingham County Courts. I agree and consent to jurisdiction of said Court, and will not contest its jurisdiction over me.

I have read and fully understand the terms and conditions set forth above.

\_\_\_\_\_  
Signature of Owner or Agent

Date: \_\_\_\_\_

Phone number owner can be reached today and/or tomorrow: \_\_\_\_\_