



## ANIMAL CLINIC OF WEST PLAINS, INC.

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### ABSENT OWNER FORM

To be filled out by the owner and used in case their pet(s) needs emergency care at Animal Clinic of West Plains, Inc., while the pet(s) are in the care of another person.

Client ID#: \_\_\_\_\_ Client Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Departure Date: \_\_\_\_\_ Returning: \_\_\_\_\_

Contact Phone Number(s) while you are away: \_\_\_\_\_

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#### Person(s) taking care of pet(s) during my absence:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Staying at my residence?  Yes  No If no, address \_\_\_\_\_

#### Please check one of the following statements:

The agent above is responsible for my pet(s) while I am away and will be able to make all decisions regarding veterinary care for the pet(s) listed below.

The agent stated above is responsible for my pet(s) while I am away. For decisions regarding veterinary care, I wish to be contacted at the numbers listed above.

If I am not available, I appoint \_\_\_\_\_ at \_\_\_\_\_  
to act on my behalf. (Name) (Phone)

If I am not available, I authorize the Animal Clinic of West Plains to start treatment, not to exceed \$ \_\_\_\_\_ until I can be reached for further authorization.

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#### FINANCES:

I authorize the use of my card number to be used only while I am away (see the dates above), by the Animal Clinic of West Plains, Inc. to pay for any medical expenses that my pet(s), listed on page 2, 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.

I authorize a maximum of \$ \_\_\_\_\_ to be used towards my pets care at the Animal Clinic of West Plains, Inc.

Card Type: \_\_\_\_\_ CC #: \_\_\_\_\_ Exp: \_\_\_\_\_

Name (as it appears on the card) \_\_\_\_\_

Cardholders Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Other Financial Arrangements: \_\_\_\_\_

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**Pets Authorized for Treatment.** Please fill out completely so we can provide the best care for your pets while you are away.

I authorize treatment for all active pets listed under my client account.

I authorize treatment only for the pets listed below.

Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Color: \_\_\_\_\_

Is this pet an active patient?  Yes  No

Does this pet have any special needs/medical conditions/on medications?  Yes  No

Notes: \_\_\_\_\_

Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Color: \_\_\_\_\_

Is this pet an active patient?  Yes  No

Does this pet have any special needs/medical conditions/on medications?  Yes  No

Notes: \_\_\_\_\_

Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Color: \_\_\_\_\_

Is this pet an active patient?  Yes  No

Does this pet have any special needs/medical conditions/on medications?  Yes  No

Notes: \_\_\_\_\_

Name: \_\_\_\_\_ Species: \_\_\_\_\_ Breed: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Color: \_\_\_\_\_

Is this pet an active patient?  Yes  No

Does this pet have any special needs/medical conditions/on medications?  Yes  No

Notes: \_\_\_\_\_

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I hereby authorize the veterinarian to examine, prescribe for or treat the above described pet(s). I assume responsibility for all charges incurred in the care of my pets. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment. As part of the consideration hereof, I agree to pay all costs of collection, including but not limited to all court costs and reasonable attorney's fees if this account is placed in the hands of an attorney for collection.

Owner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Accepted by \_\_\_\_\_ for the Animal Clinic of West Plains, Inc.