downtown
VETERINARY MEDICAL HOSPITAL
www.dvmhospitals.com

West Village
Veterinary Hospital
75 8th Avenue
New York, NY 10014
212-633-7400
212-807-1587 (FAX)
www.westvillagevets.com

Tribeca Soho
Animal Hospital
5 Lispenard Street
New York, NY 10013
212-925-6100
212-925-1676 (FAX)
www.tribecavets.com

Battery Park
Veterinary Hospital
21 South End Avenue
New York, NY 10280
212-786-4444
212-786-4040 (FAX)
www.batteryparkvets.com

Seaport Animal Hospital
80 Beekman Street
New York, NY 10038
212-374-0650
646-937-5697 (FAX)
www.seaportanimalhospital.com

CLIENT ESTIMATE OF COSTS AND CONSENT FOR HOSPITAL SERVICES-
-Downtown Veterinary Medical Hospitals, PLLC-

Client: _____ Date: _____

Patient: _____ Procedure _____ Days in Hospital _____

I am the owner of the above Patient and have the authority to exercise this consent. By signing below I request, authorize, and consent to hospitalization for the above procedure(s), diagnostic test(s), operation(s), treatment(s), or other service(s), referred to hereinafter as Hospital Services. I have been advised as to the need and nature of these Hospital Services, the risks involved, alternate therapies (if any), and possible complications. I understand that unforeseen circumstances may arise or may be revealed during the hospital stay and I authorize any change in Hospital Services so revealed. I authorize the use of anesthetic agents, sedatives, pain relievers, and other medications, and I understand that hospital support personnel will be used as deemed appropriate by the veterinarian. I understand that results cannot, and are not, guaranteed.

A "good faith" estimate for these Hospital Services is $_____. THIS IS AN ESTIMATE ONLY and is based on the things known about the Patient at the time the estimate is made. The final bill will be for any and all Hospital Services actually performed *and may vary substantially from this estimate*. Medications and diets dispensed are not a part of this estimate. We do not extend credit or bill for services. All open invoices are sent to collection after 30 days.

PLEASE NOTE: We cannot begin Patient care until you have confirmed your desire for us to do so by:

1) signing this authorization, and
2) leaving an initial deposit of 60% of this estimate.

These two measures are the only way that we have of knowing for certain that you want us to proceed with the Hospital Services offered. Additional payments may be required throughout the Patient's hospital stay. Any outstanding or remaining balance must be paid ***before we can release the Patient from the hospital***. In some cases, there is *no* amount of money that can guarantee a good outcome to the Patient's problem and therefore your responsibility to pay for the Hospital Services continues even if the Patient fails to respond to treatment, dies, or must be euthanized (put to sleep). We do not extend credit or accept checks that cannot be guaranteed.

I further request the use of my credit card: ☐ VISA ☐ MC ☐ Amex #: _____

Expiration Date ____ / ____ 3-digit Security Code: _____ Billing Zip-Code: _____

Name on Card: _____ Card Signature: _____

I have read, understand, and accept the above:

_____

Authorized Signature

What is the *best number* where we can most readily reach you? _____

☐ WORK ☐ CELL ☐ HOME