VETERINARIAN RELEASE

Autumn's Bed & Biscuit Pet Sitting Services

Please complete this medical authorization form prior to your service dates. Fields marked with an asterisk (*) are required.

1. CLIENT CONTACT INFORMATION

Name:* _____

Address:* _____

Phone:* _____ **Email:*** _____

2. REQUESTED SERVICES

Select the service(s) to be provided:*

☐ Dog Walking/Drop-In Visits ☐ In-Home Boarding ☐ Dog Daycare ☐ Overnight Care/24Hr Nanny Care

3. VETERINARY MEDICAL TREATMENT AUTHORIZATION

EMERGENCY CARE MANDATE: IF MY PET HAS AN INJURY, AN ILLNESS, OR FOR ANY REASON NEEDS MEDICAL ATTENTION WHILE UNDER THE CARE OF AUTUMN'S BED & BISCUIT PET SITTING SERVICES, I HEREBY AUTHORIZE GLENDA GABLE OR HER FAMILY MEMBERS TO SEEK PROFESSIONAL MEDICAL ATTENTION AT MY REGULAR VETERINARIAN OFFICE OR THE NEAREST VETERINARY CLINIC THAT IS OPEN. **FINANCIAL RESPONSIBILITY:** IN THE EVENT OF A MEDICAL EMERGENCY, I AUTHORIZE AUTUMN'S BED & BISCUIT PET SITTING SERVICES TO SEEK VETERINARY CARE FOR MY PET IF I CANNOT BE REACHED IMMEDIATELY. THE CLIENT IS SOLELY RESPONSIBLE FOR ALL VETERINARY EXPENSES INCURRED. THE PET SITTER WILL NOT ADVANCE, PAY, OR BE FINANCIALLY RESPONSIBLE FOR ANY VETERINARY COSTS. CLIENTS MUST PROVIDE A VALID CREDIT CARD AUTHORIZATION ON FILE WITH THEIR VETERINARIAN OR LEAVE AN EMERGENCY PAYMENT METHOD WITH THE PET SITTER PRIOR TO THE START OF SERVICES. BY SIGNING BELOW, THE CLIENT ACCEPTS FULL LEGAL AND FINANCIAL RESPONSIBILITY FOR ANY VETERINARY TREATMENT PROVIDED TO THEIR PET.

4. CLINIC SPECIFICATIONS & FINANCIAL LIMITS

Maximum Authorized Payment Limit (if un-reachable):* $ _____

Designated Veterinarian / Clinic Name, Address & Phone Number:*

5. EMERGENCY CLINIC SPECIFICATIONS & FINANCIAL LIMITS

Maximum Authorized Payment Limit (if un-reachable):* $ _____

Designated Emergency/24-Hour Veterinarian / Clinic Name, Address & Phone Number:*

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6. AUTHORIZATION EXECUTION

By signing below, I certify that I am the owner or authorized custodian of the animal(s) receiving care, and I fully execute and accept all terms of this medical release form.

Owner Signature:* _____ **Date :*** _____

7. EMERGENCY CONTACT INFORMATION

Name:* _____

Address:* _____

Phone:* _____ **Email:*** _____