

# HIGH VALLEY VETERINARY HOSPITAL



1029 D Street, Ramona, CA 92065

760-788-6520

## Authorization for Treatment

I, \_\_\_\_\_ (*your name*), give \_\_\_\_\_  
\_\_\_\_\_ (*pet sitter's name*) authorization to have my pet(s)  
\_\_\_\_\_ treated by High Valley Veterinary Hospital should the  
need arise while I am out of town.

I will be out of town from \_\_\_\_\_ to \_\_\_\_\_.

I may/may not (*please circle one*) be reached while I am gone.

The telephone number I can be reached at while I am out of town is  
\_\_\_\_\_.

I authorize my agent to approve any and all charges related to treatment.  
An estimate will be made prior to treatment when possible. If I am  
unable to be reached, I authorize treatment to be done without my prior  
written approval. I agree to pay the balance due immediately upon my  
return.

\_\_\_\_\_

Signature

Date

Credit Card: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp: \_\_\_\_/\_\_\_\_ Sec. Code: \_\_\_\_\_

Limit on treatment if we are unable to reach you: \$ \_\_\_\_\_