



BEND EQUINE MEDICAL CENTER

Wayne Schmotzer, DVM, Dipl. ACVS
Wendy Krebs, DVM
Jessica Evans, DVM
Shannon Findley, DVM
Liz Pollak, DVM

Authorization and Release

I, _____, owner/agent of _____ hereby agree to hold Bend
(print name) (patient name)

Equine Medical Center and Small Animal Division, and/or Dr. Wayne Schmotzer, and/or Dr. Wendy Krebs, and/or Dr. Mary Masterson, and/or Dr. Jessica Evans and/or Dr. Shannon Findley and/or Dr. Liz Pollak/or Dr. Sam Delbecq and the aforementioned agents harmless for any injury, damage, theft, and/or death, which may befall my animal whether, caused by mishap, accident, and/or Acts of Nature.

I also authorize the above Doctors or their agents to treat any medical or surgical conditions, as deemed necessary, that may arise in my (our) absence unless otherwise stated in writing.

I authorize the use of appropriate sedation and/or other medication(s) and I understand that hospital support personnel will be utilized as deemed necessary by the veterinarian.

In case of dire need, I authorize humane euthanasia in my absence, although every reasonable attempt will be made to contact me in advance.

I further agree that my authorized agent or I will pay all past and current charges on my account. Should I fail to comply with this policy, Bend Equine Medical Center and Small Animal Division is authorized to charge my credit card for the entire balance. I realize that my account is subject to interest charges on any overdue balances and that I am responsible for all collection costs if this invoice is not paid pursuant to its terms and conditions.

Date	Owner/Agent	Procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____