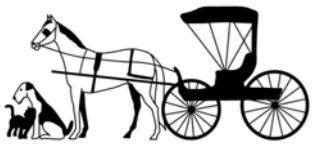
Please fill out this form,

print, sign, and send back

to JVC via fax: (317)758-6055

email: info@janssenvetclinic.com

or postal delivery.



JANSSEN VETERINARY CLINIC, LLC
2420 WEST 236TH STREET
SHERIDAN, IN 46069-9305
317-758-4865

Equine Surgery Consent Form

Procedure:_____

Client Name:_____
Address:_____
City/State:_____
Zip Code:_____
Telephone:_____
Equine Name:_____
Breed:_____
Sex: Mare Gelding Stallion
Color_____
Birthdate:_____

I certify that I own/have assumed financial responsibility for the above described animal and I do hereby consent and authorize Janssen Veterinary Clinic and its staff to hospitalize this animal, and to administer vaccinations, medications, test, surgical procedures, anesthetics or treatment that the doctors deem necessary for the health, safety or well-being of the above animal while it is under their care and supervision.

If this animal should injure itself in an escape attempt, refuse food, become ill or die while in the hospital, I will hold Janssen Veterinary Clinic free of any responsibility and/or liability in the absence of gross negligence.

A deposit of $200.00 is required for any procedure greater that $300.00.

I further realize that I am responsible for payment for the above procedures and treatments in full at the time the animal is discharged. If I neglect to pick up the animal that is ready for release, within five (5) days of written notice delivered to the above address, Janssen Veterinary Clinic may assume that the animal is abandoned. Janssen Veterinary Clinic is then authorized to dispose of it as they see fit. Abandonment does not release me of my obligation for the bill.

I further agree that in the case of non payment, a finance charge of 1 3/4% per month (21%) per annum will be charged and that any collection fees or attorney fees will be paid by me. If payment arrangements have not been made within 60 days of service, this account will be given to a collections agency. An additional non-refundable fee of $30.00 will be added to your account. This fee covers the cost of the collections agency.

Signed: _____Date:_____
Witness: _____Date:_____

JANSSEN VETERINARY CLINIC, LLC
EQUINE HOSPITALIZATION INSTRUCTIONS

Client Name:_____
Patient Name:_____

CHECK-IN WEIGHT: _____ **DATE:** _____

PREVENTATIVE VETERINARY CARE:

Last Deworming Date: _____ Product: _____

Vaccinations Due - ☐EWT ☐RF ☐WNV ☐Strangles ☐RABIES ☐PHF

Fecal Exam: ☐YES ☐NO Sheath Cleaning: ☐YES ☐NO Farrier Work: ☐YES ☐NO

Special Requests - _____

FEEDING INSTRUCTIONS:

Grain _____AM/PM Hay _____AM/PM

Supplements/Medications:
_____Dose_____ ☐AM ☐PM
_____Dose_____ ☐AM ☐PM
_____Dose_____ ☐AM ☐PM
_____Dose_____ ☐AM ☐PM

EXERCISE INSTRUCTIONS: Turnout: ☐YES ☐NO

Special Requests _____

Equipment Left with Equine: _____

Insured: ☐YES ☐NO
Insurance Co. Name: _____ Insurance Co. Phone: _____
Owner daytime phone number: _____

I have read and filled out the above recommendations that I wish my equine to have completed while hospitalized at Janssen Veterinary Clinic, LLC.

Signed:_____Date:_____