Night Owl Bird Hospital
1956 West Broadway
Vancouver BC V6J 1Z2
604-734-5100

Please take a moment to complete our client information form to ensure we have all the correct information about you and your pet. This information is for hospital communication purposes ONLY and will not be shared externally.

DATE ____

YOUR INFORMATION (Primary Contact)

FIRST NAME ____ LAST NAME ____

STREET ADDRESS____
CITY ____

PROVINCE ____________________________ POSTAL CODE ___________________________

HOME PHONE ____

WORK PHONE _________________________________

CELL PHONE ______________________________

FAX ____

EMAIL ____

Privacy Information Protection Act: No information regarding you or your pet may be released without your written authorization. Do you grant permission to any other persons including your spouse or family members to unrestricted access to your pet's medical information?

SECONDARY CONTACT (Who also has responsibility and decision-making authority for your pet)

NAME ____

RELATIONSHIP ____

HOME PHONE ____

WORK PHONE _________________________________

CELL PHONE _____________________________

Please carefully review the Treatment Authorization and acceptance of Financial Responsibility below and sign if you understand and agree with the below statement. Please let us know if you have any questions.

Treatment Authorization

I am the owner or authorized agent for the owner of the above-named pet. I have the authority to make medical decisions related to the pet. By signing this intake form, I authorize NOBH staff to provide care and perform any treatment, including the administration of anaesthesia and surgical procedure, there are risks involved, including the risk of death. I acknowledge that no guarantee or assurance is being made as to the treatment results.

Acceptance of Financial Responsibility

I understand that payment in full is required at the time of service. NOBH staff will provide an estimate of fees upon my request. I acknowledge that an estimate is only an approximation; actual fees may vary. I understand that NOBH staff will make every effort to keep me informed of the current charges and will attempt to contact me if it appears in the high range of the estimate will be exceeded. If the pet requires hospitalization, I agree to make a deposit in advance and pay balance when the pet is discharged. If I do not pick up the pet at the date and time specified by NOBH staff, additional charges will accure. I recognize that I am responsible for all charges related to the pet, regardless of treatment results. NOBH accepts payments in cash, Visa, Mastercard or Debit. I am aware that all delinquent accounts will be transferred to a collection agency.

Signature ____

Date ____