Otterdale Pet Wellness Center
7130 Cosby Village Rd
Chesterfield, VA 23832
(804) 508-7387

Disclosure and Hospital Agreement

ATTENTION: State of Virginia Law requires that we make the following disclosure and requires that you read and sign this form before we can hospitalize your animal for treatment.

Otterdale Pet Wellness Center has business and medical staff available and on duty during operational hours: Mondays and Thursdays 8:00 am to 7:00 pm; Tuesdays and Wednesdays 8:00 am to 6:00 pm; Fridays 8:00 am to 5:00 pm; and Saturdays 8:00 am to 12:00 pm. We are closed on Sundays and holidays. Care is provided during the hours of closure, but not continuously. **We do not have continuous medical care.**

_____ All animals entering the kennel for grooming must be current on all vaccinations and free of parasites both internal and external. If not, then appropriate measures will be taken to bring them current on vaccines and the parasites under control. Pets will be released during the normal business hours of operation.

_____ I am the legal owner or agent representing this animal and have read and understand this disclosure form. I am also responsible for this animal's charges. If the pet is not picked up within five (5) days of the disclosure date, we will assume the animal has been abandoned and will care for the pet accordingly. I recognize I am still responsible for all fees incurred.

Signature of Owner or Respresentative: _____

Owner & Co-Owner Name _____

Email Address _____ Phone No. _____

Mailing Address _____
Street City, State, Zip Code

Residential Address _____
Street City, State, Zip Code

DL # _____ Owner's DOB _____ Work No. _____

Employer Name & Address _____

How did you first hear of us? _____

I hereby authorize the veterinarian to examine, prescribe for, and/or treat the pet(s) in which I have brought to this facility. I assume responsibility for all charges incurred in the care of my animal(s). I also understand that all charges will be paid in full at time of release and that a deposit may be required for surgical or medical treatment

Signature of Owner or Agent: _____ Date: _____