

**AUTHORIZATION TO PERFORM
MEDICAL TREATMENT OR SURGERY**

Owner: _____ Pet: _____
Street: _____ Breed: _____
City: _____ Sex: _____
Phone: _____ Age: _____

Contact Telephone Numbers:

Day _____
Evening _____
Cell _____

AUTHORIZATION:

1. I am the owner/ guardian of the animal identified above. I am 18 years of age or older, and I have the authority to execute this authorization.
2. I hereby consent to and authorize the performance of the procedures described by the doctor. I realize that there can be no guarantee as to the animal's condition or the outcome of any procedures, and I understand the risks that may be involved.
3. I authorize the performance of the identified procedures and the use of associated anesthetics and other medications.
4. I also understand that unforeseen conditions may be revealed during the identified procedures which in the opinion of the attending veterinarian require more extensive or different procedures or treatments. I understand that reasonable effort to contact me will be made to obtain my instructions regarding them. However, if the efforts are unsuccessful, I authorize the performance of any procedures or treatments which are necessary in the professional opinion of the attending veterinarian.
5. I have had the fees outlined to me and agree to pay all such fees and charges at the time of discharge unless alternate financial arrangements have been made at time of admittance.
6. I understand that if my pet is not claimed 10 days post completion of treatment I will forfeit ownership of this pet.
7. I have read and understand this authorization.

HOSPITAL POLICY

1. Our fees are based on the current year fee schedule of the Ontario Veterinary Medical Association (OVMA)
2. Fees must be paid on the day of treatment. For your convenience, we do accept VISA, MASTERCARD, INTERAC, or CASH. Do not hesitate to discuss our fees with us if you have any questions.
3. The goal of our practice is that you attain the highest level of health possible for you, and that the staff is all working with you to achieve this. Part of your contribution to achieving your optimum health, is making and keeping regularly scheduled appointments. As much as possible, the appointments are made to fit into your schedule as well as ours. Any change in scheduling or missed appointments may affect other patients in need of treatment.
4. Appointments are reserved exclusively for you. We will attempt to remind you of your appointment a day or two in advance, however, it is your responsibility to keep your appointments.

If you have any questions concerning this estimate please do not hesitate to ask.

I have been given an estimate as to the procedure(s) and their costs: ___ verbal ___ written (see below)

I accept and agree to the terms of this estimate:

Owner's Signature

Date: _____

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For Office Use Only:

Reception: _____ Doctor: _____ Deposit: _____ Notes: