AUTHORIZATION TO PERFORM MEDICAL TREATMENT OR SURGERY

TO: SABAL CHASE ANIMAL CLINIC (IAN BRUCE KUPKEE DVM)
10710 SW 113th Place, Miami FL 33176 (305-595-1450)

Date:_____ **Procedure:**_____

Owner:_____**Pet Name:** _____

Address:_____ **Species:** _____ **Breed:**_____

_____ **Color:** _____ **Sex:** _____

AUTHORIZATION:

1. I understand no additional work will be done, such as extractions and growth removals, found after drop off without verbal consent. Please leave a contact number we can reach you at immediately. Initial: __
2. I am the owner of the animal identified above. I am 18 years of age or older, and I have the authority to give this authorization and do so voluntarily, having been advised of all of the probable and material risks associated with this treatment.
3. Dr. Kupkee and agents has described the procedures identified above and has explained to my satisfaction the purpose for performing them and the risks involved with them. I realize that there can be no guarantee as to the animal's condition or the outcome of any procedures. In particular, I have been advised that, in the event that the treatment requires the use of anesthesia, that there is a risk of death every time an anesthetic is used. I also understand that all reasonable precautions against injury, escape or harm will be taken. I have been advised of the likelihood of such an occurrence and I will hold you blameless if such events occur.
4. I authorize the performance of the identified procedures and the use of associated anesthetics and other medications.
5. 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 efforts will be made to contact me to explain these procedures and treatments and 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.
6. I also understand that if fleas or ticks are found on my pet, Sabal Chase Animal Clinic will treat or medicate as needed and I will be responsible for all charges.
7. I have agreed to pay $_____ for the above procedures and related clinic fees. I will pay this money at the time the animal is discharged and hereby acknowledge my indebtedness for this amount.
8. Preanesthetic bloodwork must have been performed within the past 3 months. If you pet has not had preanesthetic bloodwork, there will be an additional charge of $82.50. Initial: ___
9. I have read and understand this authorization.

Would you like a microchip today? A microchip serves as a permanent identification in the event that your pet is to be lost or stolen. Yes:__ No: __

Contact Number: _____Alternate Number: _____

OWNER or Authorized Agent: _____ Witness:_____