

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:** _____