

AUTHORIZATION FOR PROFESSIONAL SERVICES

The following information is necessary in order that we might serve you better and give you more personal attention. **Please fill out this form completely.**

OWNER _____ PET'S NAME _____
PHONE NUMBER WHERE YOU CAN BE REACHED TODAY IN CASE OF
EMERGENCY: _____

I hereby authorize the following procedure(s):

I understand that before anesthesia or surgery, it is sound medical procedure to perform a **PRE-OP BLOOD TEST** for the purpose of discovering subclinical disease. If there is any indication of organ dysfunction, then the appropriate steps can be taken to ensure the safety of your pet.

I DO _____ DO NOT _____ wish for a pre-op blood test performed on my animal.

Age of animal _____

If the procedure being performed is a **DENTISTRY**,

I DO _____ DO NOT _____ give permission to pull teeth if the clinic deems necessary.

If the procedure being performed is a **GROWTH REMOVAL**,

I DO _____ DO NOT _____ give permission to perform histopathology if the growth appears suspicious.

POST-OPERATIVE PAIN CONTROL is an option available to your pet. Various forms of pain control are available and cost will depend on type of pain control administered.

I DO _____ DO NOT _____ want additional pain control medications for my pet.

The nature of such service has been described to me to my satisfaction and I realize that no guarantee nor warranty can ethically or professionally be made regarding the results of cure.

I understand that I assume financial responsibility for all services rendered, and that payment is due on the date of discharge from the clinic.

Signature _____ Date _____