

**Richfield Area Pet Clinic LLC
1275 Morgan Drive
Hubertus, WI 53033**

Authorization for Spay / Neuter / Declaw / Dental Surgery

Client _____ Pet _____

Anesthetic and surgical procedure(s) to be performed:

-
- | | | |
|---|------------------------|---------|
| Pre-Anesthetic Bloodwork (Highly recomm; Required if pet >7 yrs old) | Accept ___ Decline ___ | \$58.00 |
| - Detects internal organ malfunction or damage that may make anesthesia/surgery dangerous | | |
| Pre-Anesthetic ECG (Highly recommended) | Accept ___ Decline ___ | \$45.00 |
| - Detects heart problems that may make anesthesia or surgery dangerous | | |
| Microchip | Accept ___ Decline ___ | \$42.00 |
| - Permanent ID for your pet in case lost or stolen | | |
| Laser | Accept ___ Decline ___ | \$70.00 |
| - Reduced bleeding, pain, swelling | | |
| Elizabethan ("Cone") Collar | Accept ___ Decline ___ | \$ |
| - Helps prevent post-surgical trauma to incision site from licking or chewing | | |

I, the undersigned owner or agent of the owner of the identified above, certify that **I am** eighteen years of age or over and authorize the veterinarian(s) at Richfield Area Pet Clinic LLC, to perform the above procedure(s). I understand that some potentially serious risks, including death, always exist with anesthesia and/or surgery, and that I am encouraged to discuss any concerns I have about those risks with attending veterinarian before the procedure(s) is/are initiated. I will not hold the Clinic, its doctors, or employees responsible for any complications, including death, that may result from my decision to decline any of above options. My signature on this form indicate\s that any questions I have regarding the following issues have been answered to my satisfaction:

- The reasonable medical and/or surgical treatment options for my pet
- Sufficient details of the procedures to understand what will be performed
- How fully my pet will recover and how long it will take
- The most common and serious complications
- The length and type of follow-up care and home restraint required
- The estimate of the fees for all services

While I accept that all procedures will be performed to the best of the abilities of the staff at this hospital, I understand that no guarantee or warranty has been made regarding the results that may be achieved, and I assume all risks inherent in this procedure. I assume full financial responsibility for all fees and costs, and agree to provide payment via cash, credit card, or check at the time my pet is discharged from the hospital, or treatment is completed/terminated.

Should unexpected life-saving emergency care be required and the hospital staff is unable to reach me, the staff **HAS _____ DOES NOT HAVE _____** (check one) my permission to provide such treatment and I agree to pay for such services.

I certify that my pet has been fasted for a minimum of 10 hours before the procedure.

I have read and fully understand the terms and conditions set forth above.

Signature of Owner or Agent

Date

Phone number where you can be reached TODAY _____