



Animal Hospital

SURGICAL AUTHORIZATION FORM

PET OWNER: _____

OWNER'S ADDRESS: _____

PHONE NUMBER: _____ CELL: _____

I authorize Country Club Animal Hospital (CCAH) and its staff to contact me via phone and text messages.

Consumer information is not shared with third parties for marketing purposes.

PET'S BREED: _____ NAME: _____ PET'S COLOR: _____ SEX _____

I certify that I own the above described pet, and I do hereby authorize Country Club Animal Hospital (CCAH) and its staff to perform the following surgical procedure(s) on my pet as listed below:

1) _____ 2) _____

I understand that during the performance of the surgical procedure(s), unforeseen conditions may be discovered that necessitate more extensive or different surgical procedure(s) to be performed than those originally set forth above. Therefore, I hereby authorize the performance of such treatments or surgical procedure(s) deemed necessary in the Veterinarian's best professional judgement. Any additional time and/or materials needed, as a result of unforeseen circumstances, will be billed for at normal hospital rates, in addition to any fees previously quoted for the surgical procedure(s).

I also authorize the use of appropriate anesthetics, medications, fluids, laboratory testing, monitoring equipment, and hospital support personnel as deemed necessary by the Veterinarian to insure the safest possible induction, maintenance, and recovery from anesthesia and surgery.

I have been advised as to the nature of the surgical procedures to be performed and the relative risks involved. I fully realize that the end results cannot be guaranteed.

An **APPROXIMATE QUOTATION** of fees for a surgical plan will be provided **UPON REQUEST** and an appropriate deposit may be required. I further realize that I am responsible for payment in full for the above surgical procedure(s), plus any additional treatments at the time the pet is discharged. If I neglect to pick up my pet within five (5) days of receiving written notice that my pet is ready for release and mailed to the above address, CCAH may assume that the pet is abandoned. CCAH is then authorized to dispose of my pet as CCAH sees fit. Abandonment does not release me of my obligation for payment of the total bill.

The burden to keep in constant touch with the Doctors of CCAH about the progress, condition, treatments, and time of release of my pet from CCAH will be the sole duty of the pet owner. If different from pet owner's name listed above, please list one family member/contact person for CCAH to contact. _____

I further agree that in the case of non-payment, a finance charge of 1 1/2% per month (18 % per annum) will be charged and that any collection fees or attorney fees for collection will be paid by me.

I have read and fully understand the above document and agree to all of its

conditions. OWNER'S SIGNATURE: _____ DATE: _____

CCAH WITNESS TO SIGNATURE: _____ DATE: _____

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