Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Owner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Species: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Breed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number that you can be reached at today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service(s) to be performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Read Carefully and Sign:**

I, the undersigned owner, or authorized agent of the pet identified, authorized the veterinarian(s) and staff at Angelina Animal Hospital to perform the above procedure(s). I understand that some risks are always exist and that I am encouraged to discuss and concerns that I have about the risks with the attending veterinarian before the procedure(s) is/are initiated. My signature on this form indicates that any questions that I may have regarding the following issues have been answered to my satisfaction.

* 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 most serious complications
* The length and type of follow-up care required
* The estimate of the fees for all services provided
* **May muzzle if needed**

**Before performing the above agreed upon services, your pet must be up to date (minimum of Rabies) and free of any external parasites, i.e. fleas and ticks.** We also highly recommend testing for heartworms and intestinal parasites. If your pet is not current on the above, *additional charges* may be incurred to have these completed and cleared by our hospital. *Each animal at AAH is required to be flea free, AAH staff will administer a Capstar at owners’ expense if fleas are seen while being treated.*

 Deposit for today’s services $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ initial\_\_\_\_\_\_\_\_\_\_

Estimate for today’s services$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ initial\_\_\_\_\_\_\_\_\_\_

Veterinarian who administered Rabies Vaccine: Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact? Y/ N

Date Administered: \_\_\_\_/\_\_\_\_/\_\_\_\_ EXP: \_\_\_/\_\_\_/\_\_\_\_ Phone:(\_\_\_\_)-\_\_\_\_\_-\_\_\_\_\_\_\_\_

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. I agree to assume fiscal responsibility and provide payment via cash, check, or credit card. I have read and fully understand the terms and conditions set forth above.

Signature of Owner

or Authorized Agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_