



Maul Road Animal Clinic
 1249 Maul Road Camden AR 71701
 Betty S. Rigby, DVM

**AUTHORIZATION FOR MEDICAL TREATMENT
 AND/OR SURGICAL PROCEDURE**

| AUTHORIZATION | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| <p>I, the undersigned, do hereby certify that I am the owner or duly authorized agent for the owner of the animal described below. I hereby give Maul Road Animal Clinic, their agents, employees, and representatives, full and complete authority to perform the medical and/or surgical procedure and anesthesia stated below. I release Maul Road Animal Clinic, their agents, employees, and representatives from any liability for performing the procedure described below.</p> <p>I agree to pay in full for the services rendered including those deemed necessary for medical or surgical complications or otherwise unforeseen circumstances. The final bill may be less or greater than any estimated amount. I agree that MRAC, or an agent of, may contact me at my cell phone number in order to service my pets or account.</p> | | |
| OWNER/AGENT | | |
| First Name | Last Name | Client ID # (office use only) |
| Home Phone | Emergency Phone | Mobile Phone |
| PET | | |
| Name | Age | Species: DOG / CAT |
| TREATMENT OR PROCEDURE | | |
| <p>PRE-ANESTHESIA BLOOD TESTING We recommend a pre-operative blood screen to identify any existing internal problems not evident on physical examination prior to anesthesia. This will add an additional \$36.00 to your total.</p> <p><input type="checkbox"/> Accept <input type="checkbox"/> Decline</p> | | |
| <p>POST-OPERATIVE PAIN MANAGEMENT For your pet's comfort, we offer medicine to alleviate post-surgical pain. This is available at an additional cost which is based on your pet's weight.</p> <p><input type="checkbox"/> Accept <input type="checkbox"/> Decline</p> | | |
| PROCEDURE SPECIFIC INFORMATION | | |
| <p>OVARIOHYSTERECTOMY-</p> <p>_____ Due to increased difficulty, I understand that there is an additional cost of \$29.00 if my dog is in heat. No additional charge for cats in heat.</p> <p>Pregnancy is a possibility in most adult females and often isn't detected until we have started the surgical procedure. If my pet is pregnant, I would prefer to: _____ Stop the procedure. I understand that I will be charged for surgery time, anesthesia, and supplies. _____ Continue with the procedure. I understand that there is an additional cost if my pet is pregnant.</p> | | |
| <p>PROFESSIONAL DENTAL CLEANING-</p> <p>It may be necessary to extract loose, abscessed, severe root exposed, split, broken, and even retained deciduous (baby) teeth or place your pet on antibiotics to combat the abundant bacteria in the mouth.</p> <p>_____ I understand that these additional services are beneficial for my pet and that they carry an additional cost.</p> | | |
| <p>VACCINATIONS I would like to vaccinate my pet for Rabies and/or other diseases.</p> <p><input type="checkbox"/> Accept <input type="checkbox"/> Decline _____</p> | <p>MICROCHIPPING I would like to microchip my pet with an AVID ID chip.</p> <p><input type="checkbox"/> Accept <input type="checkbox"/> Decline</p> | |
| <p>GROWTH/TUMOR REMOVAL _____ I would like to have a histopath performed. I understand that this will add \$73.00 to my total.</p> | | |
| Owner/Agent Signature | | Date |
| Witness Signature | | Date |

Thank you for giving us the opportunity to care for your pet!