Kent Veterinary Center

Judy Tubman, V.M.D

32139 Chesterville Bridge Rd. - Millington, MD 21651
Office: (410) 928-5700 Fax: (410) 928-3541
www.KentVeterinaryCenter.com

Authorization for Anesthesia and/or Surgery or Procedures

Client Name: _____
Contact Phone Numbers: _____
Pet's Name: _____ Species: _____
Breed: _____ Age: _____ Sex: _____

Anesthetic and surgical procedures(s) to be performed: -

_____
_____
_____

Any joint injections can become infected or possibly experience a joint flare. This may require immediate treatment & may result in possible lameness.

I, the undersigned owner or agent of the owner of the pet identified above, certify that I _____**am/am not**_____ (check one) eighteen years of age or over and authorize the veterinarian(s) at Kent Veterinary Center to perform the above procedures(s). I understand that some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks with the attending veterinarian before the procedure(s) is/are initiated. My signature on this form indicates 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_____
Any necessary payment arrangements.

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 pay a deposit of _____% of the estimated fees, assume financial responsibility for the remaining fees, and provide payment via cash or credit card at the time my pet is discharged from the hospital. 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 have read and fully understand the terms and conditions set forth above.

_____ _____
Signature of Owner or Agent Date

_____ _____
Signature of Parent or Legal Guardian Date
(If owner/agent less than 18 years of age)