LIBERTY VET PETS

Standard Consent Form (Mass Removal)

To: Liberty Vet Pets: Dr. Bonnie Valiente, VMD

Owner's Name:_____
Address:_____
Home Number and Name of person to reach: _____
Emergency Number and Name of person to reach: _____
Patient's Name:_____
Species: Please Circle (Dog/Cat/ Horse/ Other)_____
Breed:_____
Sex: Please Circle (FI / FS / MI / MC)_____
Date of Birth & Age:_____

I am the owner or the agent for the owner of the animal described above, and I have the authority to execute this consent.

Please list or describe any medical problems, known allergies, illnesses or concerns that our doctor(s) should be made aware of: _____
As the owner or agent for the above-described animal and with the authorization to execute this consent I HEREBY CONSENT AND AUTHORIZE Dr. Bonnie Valiente VMD /staff to perform THE FOLLOWING TESTS, PROCEDURES, OPERATIONS (please list or describe or write "As Per Estimate" if you have received an estimate): Owner is aware of the pros and cons of Sedation and Mass Removal

The nature of these operations or procedures has been explained to me, and I understand what will be done. I have also been informed that there are certain risks and complications associated with any operation or procedure of this type. They have been explained to me as well. I further understand that during the course of the operations or procedures, unforeseen conditions may arise that may necessitate the performance of additional procedures and/ or necessitate an extension of foregoing procedure(s) than those set forth above.

I authorize the use of appropriate anesthesia and pain relief medication as needed before or after the procedure. I have been informed that there are risks associated with the use of any medication.

I understand that hospital support personnel will be used as deemed necessary by the veterinarian. I hereby consent to and authorize the performance of such procedure(s) or as are necessary and desirable in the exercise or the Veterinarian's professional judgment. I have been advised and able to ask questions and have been informed of the risks of the procedures, treatments and/ or medications. Due to the nature of medicine, I also realize that the results cannot be guaranteed.

PAYMENT POLICY: payment must be made in FULL BEFORE patient can be released from care. Before the treatment is initiated or services are rendered, would you like a written estimate of cost? Yes ◯, No ◯ . I Plan to pay by : ☐ Cash, ☐ Visa/ Mastercard, ☐ Discover/ American Express

I have read and understand this Authorization and Consent Signed

(Signature of owner or agent here): X _____Date: _____

(Signature of Employee Witness to Above Signature) X_____ Date: _____