CITRUS ANIMAL CLINIC
270 US 27 South
Lake Placid, FL 33852
863-465-2176

AUTHORIZATION FOR PROFESSIONAL SERVICES

The following information is necessary in order that we may serve you better and give you attention that is more personal. Please fill out the form completely.

Owner: _____

Pet's Name: _____ **Breed:** _____ **Sex:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone (Daytime): _____ **(Evening):** _____

I hereby authorize performance of the following surgical procedure(s):

_____

_____

_____

_____

I understand that during the performance of this procedure(s), unforeseen conditions may be revealed that necessitate an extension or variance of the procedure(s) set forth above. I expect Citrus Animal Clinic to use reasonable care and judgment in performing the procedure(s). The natures of the procedure(s) and risks involved have been explained to me and I realize results cannot be guaranteed. I am also aware that unforeseen events resulting from the procedure will not relieve me from any obligation to all reasonable costs incurred regarding the animal.

I understand that I assume financial responsibility for all services rendered, and that payment is due on the date of the services.

Date: _____

Signature: _____
(Owner or agent of owner)