

HARRISON EQUINE PLLC  
P.O. Box 996  
Berryville, VA 22611  
harrisequine@verizon.net  
Office: 540-955-3001  
Fax: 540-955-0942



## FINANCIAL ESTIMATE & INFORMED CONSENT FORM

Date: 4/7/11

Client Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Breed: \_\_\_\_\_

### **ESTIMATE**

The cost for the attempted medical and/or surgical care of your animal for \_\_\_\_\_ is estimated to be between \_\_\_\_\_ and \_\_\_\_\_. Please recognize that this estimate is only an approximation of the final cost to you for the attempted treatment of your horse. The final cost of treating your horse may be substantially different if additional disease conditions or complications develop. Pre-Anesthetic blood work and stall board 24 hours before and 24 hours after a surgical procedure are included in the estimate.

A daily fee will be charged for additional stall board. Shoes must be removed for all general Anesthesia cases prior to admittance. **Client will be charged \$12 per shoe if removed by Harrison Equine.**

### **PAYMENT (HAS BEEN DISCUSSED WITH CLIENTS BY \_\_\_\_\_ (Initials)**

Payment is expected at the time service is rendered. If your horse is hospitalized, **a deposit of 50% is required at the time of admission and the balance is due before the horse is released from the hospital.** We realize that veterinary services may become necessary at times that are financially inconvenient; therefore, we do accept Visa, MasterCard, Discover and American Express.

If it is necessary to bring an action to compel the payment of fees or costs, the undersigned shall pay all costs incurred in collection of the debt and reasonable attorney fees. If suit is initiated to enforce the terms of this agreement, the courts of the State of Virginia shall have jurisdiction over each of the undersigned makers and the venue of the suit, at the option of the holder of this agreement, may be in Clarke County, Virginia.

### **ANESTHESIA RISKS**

The use of anesthesia, sedation, or other medications is often necessary for diagnostic and therapeutic procedures performed by Harrison Equine. I understand that the risk of death or injury during anesthetic induction, positioning and recovery is present. I further understand that risks are greatest in horses with colic and in very young or very old, large, toxic or medically compromised patients. Both anesthesia and severe illness constitute substantial stresses for the affected animals. Horses which are seriously ill or

anesthetized can develop diarrhea, laminitis, musculoskeletal problems, pleuropneumonia or severe infections. These conditions are expensive to treat and often cannot be resolved satisfactorily thereby necessitating euthanasia.

**CONSENT**

I, the undersigned, do hereby certify that I am the owner (or duly authorized agent of the owner) of the animal identified herein and that I do hereby authorize the above identified veterinary hospital, their agents and/or representatives to perform the surgical and/or medical procedures to administer anesthesia, x-ray examination, drugs and/or medications and/or to perform other diagnosis and/or treatment which the attending veterinarian deems necessary.

I further authorize the performance of procedures and/or administration of drugs and/or medications which are in addition to or different from those now contemplated and/or those which may have been explained to me, if unforeseen conditions arise in the course of treatment of operation and such additional and/or different procedures and/or medications or drugs are judged necessary by the attending veterinarian.

I further certify that the nature and purpose of the contemplated procedures, identifiable alternative methods of treatment, risks involved and possibility of complications, have been explained to me and are understood by me, and that I recognize no guarantees or assurances have been given me as to results which may be achieved.

I take full responsibility for all charges incurred for this case and agree that payment of these charges will be made or arranged for before the horse is released.

**VISITING/DISCHARGE POLICY**

I understand that I may be able to visit my animal while hospitalized between the hours of 8:00 AM to 5:00 PM Monday-Friday. Visitation on the weekends must be pre-arranged with the attending veterinarian.

**I understand that no animals will be discharged from the hospital without prior arrangement and that payment is due in full before patient is discharged unless other arrangements are made with the attending veterinarian.**

I understand that the hospitalization fees are a minimum of \$45.00

I hereby state that I have read and understood this authorization and release and acknowledge receipt of a copy thereof.

If signing as agent of the owner, the undersigned warrants that he/she has authority to bond the owner.

**OWNER'S EMERGENCY NUMBER(S):** \_\_\_\_\_

**OWNER'S FAX NUMBER(S):** \_\_\_\_\_

**OWNER'S E-MAIL ADDRESS:** \_\_\_\_\_

**X-RAYS AVAILABLE?** \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**

**IF SO, PLEASE SEND TO HARRISON EQUINE PRIOR TO ADMISSION.**

**OWNER/AGENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**VETERINARIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_