PRINT

AUTHORIZATION & CONSENT TO PERFORM PROFESSIONAL SERVICES

PANORAMA EQUINE MEDICAL & SURGICAL CENTER
Wallace H. Liberman, D.V.M. & Associates
10302 Old Oregon Trail, Redding, CA 96003
Telephone: (530) 221-7004 / Fax: (530) 221-0345

I, _____, owner or authorized agent of the Horses in my care or possession, legally or physically, hereby authorize Wallace H. Liberman, DVM, or a veterinarian of his choice, to perform professional services (such as, but not limited to examinations and procedures, diagnostics, and surgery) upon the horse(s) presented whether by myself or other party (in case of emergency). Said veterinarian will perform any other therapeutic procedure his/her judgment may dictate to be advisable for the patient's well being. No warranty or guarantee has been made as to the result or cure.

I consent to the administration of such anesthetics as may be necessary or advisable by the veterinarian responsible for these services in order to complete the operation(s) or procedure(s).

I understand **Panorama Equine Medical & Surgical Center** and its employees will use all reasonable precautions against escape or destruction of said animal(s). However, it is understood by me that **Panorama Equine Medical & Surgical Center** shall not be, and is not, responsible beyond such reasonable precautions for said animal(s). Should hospitalization be necessary, it is understood there may be short periods of time when staff will not be physically present.

I consent to the photography of the operation(s) and/or procedure(s) to be performed; including appropriate portions of the body, for medical, scientific, or educational purposes provided identity is not revealed by the pictures or by descriptive texts accompanying them. ***INITIAL HERE IF IDENTITY CAN BE REVEALED:*** _____

It is also understood by me, and I agree, that I shall be responsible for the costs in connection with any reasonable care and/or medical treatment of any sort and description given to said animal(s) and that payment shall be made by me, upon request and prior to the return of said animal(s) to my care. If I enter into a special agreement with **Panorama Equine** for future payment of services, I understand that if the balance is not paid within 45 days of billing, my account will be referred to a collection agency and I agree to assume any and all costs associated with this action.

It is further understood by me that, if the animal dies or requires euthanasia in the hospital setting, the veterinarian(s) may, at his/her sole discretion, dispose of deceased animal(s). It is also understood by me this service will be my monetary responsibility and does not relieve me of the costs of services rendered.

I hereby certify that I have carefully read the above authorization and understand that payment in full is required before said animal will be released from the hospital.

Acceptable methods of payment: (CIRCLE ONE)

Cash Check Visa MasterCard Discover Card CareCredit®

Owner's Signature_____ Date_____