INFORMED CONSENT TO TREATMENT Client ID: {ID} Patient ID: {PATIENTID}

1. I, the undersigned, an adult major, hereby authorise the veterinarians and staff of this veterinary facility to perform any reasonable treatment/anaesthesia and surgery they may deem necessary, including further or alternative measures as may be necessary during the course of the surgery and/or treatment of my animal.
2. **I am aware that this veterinary facility does not provide 24-hour per day monitoring of patients**. In the event that my pet requires overnight hospitalisation, I will arrange for collection and return of my pet to and from a suitable facility.
3. I recognise that there is some degree of risk, including death, attached to any medical or surgical procedure or treatment. I have discussed any concerns I may have with the veterinarian. I hereby absolve the veterinarians, staff and this facility from all actions, arising directly or indirectly from the treatment / anaesthetic / surgery.
4. I agree to pay all costs associated with treatment regardless of outcome prior to the discharge from hospital of my animal. In the event of non payment I understand and consent to any legal means or action being taken to recover outstanding monies. I am liable for all additional costs - legal or otherwise - for recovery of any outstanding monies.
5. I acccept that I am fully accountable for my pet licking out stitches after surgery; that I will be responsible for all professional fees related to the wound being repaired, including anesthetic, surgery, hospital and after hours fees and accept that I have no claim of any nature against this facility or its staff in this event. I understand that an elizabethan collar will assist in preventing my animal from being able to lick the wound, **but have declined to fit one to my pet (delete if not applicable).** I understand that it will take a period for my pet to adjust to wearing the collar and that removing it at any time will place the wound at risk.
6. I acknowledge that it may become apparent and necessary during any dental procedure to extract teeth. In some cases, this might lead to the removal of many or all teeth, at the sole discretion of the veterinarians and staff of this facility.
7. In the event of any grievance or dispute with this veterinary facility or its veterinarians, I undertake to enter into and complete an Alternate Dispute Resolution process, before resorting to any other action or remedy.
8. I understand and accept that all clinical notes are the sole property of Applecross Veterinary Hospital (AVH) and that neither I, nor any pet insurance company have any rights to these; that AVH are not obliged to provide reports to any third party; and that if I wish to make use of pet insurance that I will preserve invoices for veterinary care for presentation to the insurer.
9. I acknowledge that this facility is not party to my arrangement with my pet insurer and that no obligations whatsoever are placed on this facility. This facility will not deal with or provide information to pet insurers. I am solely responsible for payment of veterinary fees to this facility and I hereby absolve this facility from all actions, arising directly or indirectly from my pet insurance arrangement.
10. **This facility will not provide any opinions, reports, certificates, comments, recordings or copies of clinical notes to any person for any purpose, under any circumstances.**
11. I acknowledge that I have read these conditions and hold myself bound thereto.

NAME OF PET:_____

AGE: _____ SEX: _____ BREED: _____WEIGHT:_____

****PRELIMINARY DIAGNOSIS / PROCEDURE_____**

****ESTIMATED COSTS FOR THE PROCEDURE AND/OR FIRST 24 HOURS: $_____**

(Costs may vary substantially up to 20% due to unforeseen circumstances).

FULL NAME OF OWNER/PERSON RESPONSIBLE FOR ACCOUNT (delete whichever not applicable)

NAME:_____

CONTACT TELEPHONE NUMBER:_____._____

(Would you like text message sent to your mobile to notify you when your pet is ready for collection? YES / NO)

RESIDENTIAL ADDRESS: _____

_____

E-MAIL:_____

Does your pet have any pre-existing medical conditions?_____

Is your pet on any medications? _____

I will be paying my account at discharge by CASH [ ] EFTPOS [ ] CREDIT CARD [ ]

SIGNED: _____DATE: _____

WITNESS: _____

ANDRICITY PTY LTD trading as APPLECROSS VETERINARY HOSPITAL PO BOX 891 CANNING BRIDGE WA 6153
Phone 08 9364 7666 info@applecrossvet.com.au ABN 52 098 461 628