

LEBANON EQUINE CLINIC
1200 Oregonia Road
Lebanon, OH 45036
Phone 513-932-4181 Fax 513-932-8340
www.lebanonequineclinic.com



HOSPITALIZATION CONSENT
AND FEE ESTIMATE

Owner Information

Name

Address

City, State, Zip

Home Phone

Work

Cell

E-mail

Employer

Work Address

Patient Description

Name

Registered Name

Breed

Sex

Age

Color/Markings/Identification

Reason for Hospitalization

Referring Veterinarian

Phone

Fee Estimate

| | | | | |
|---|--------------------|-------------|-----------|----|
| Initial Exam | Routine visit | Referral | Emergency | \$ |
| Hospitalization (per day) \$ _____ x _____ days = | Standard | Isolation | ICU | |
| Laboratory | Blood | Fecal | Culture | |
| Diagnostic Procedures | Radiology | Ultra Sound | | |
| Therapeutics | In-House Treatment | Fluids | | |
| Pharmacy | Medication | Materials | Discharge | |
| TOTAL | | | | \$ |

Payment in full is required when your horse is released. You have been advised of estimated costs and procedures. Please feel free to discuss the proposed treatment and its cost with your veterinarian. A minimum deposit of 50% of the estimate will be required at the time of admission.

Amount of Deposit \$ _____ Payment method _____ Received by _____

STATEMENT OF OWNERSHIP AND CONSENT:

- I am the owner of the above described horse or have authorization from the owner to consent to its treatment and am over the age of 18.
- I hereby authorize the veterinarians at Lebanon Equine Clinic and their staff to perform necessary diagnostic, therapeutic, anesthetic, and surgical procedures necessary for my horse's treatment. I authorize any procedure in addition to or different from the above, including euthanasia to avoid unnecessary suffering by my horse.
- I accept financial responsibility for these services.
- I have read the above consent and understand why the above procedures may be necessary. I also have been told of the possible complications and alternatives to the listed procedures.
- I will not hold Lebanon Equine Clinic or its agents liable in any manner regarding the care, treatment, or safekeeping of the horse described above.

I understand that if further services are required for this horse (even if for treatment of the same condition), additional expenses will occur. Do not allow the total bill to exceed \$ _____ without my authorization.

The risks involved and possible complications have been explained to me by my veterinarian. I acknowledge that no guarantee has been made as to the results that may be obtained.

I understand that if the horse I am admitting to Lebanon Equine Clinic is covered by insurance, it is necessary for me to notify the agent or adjuster of the procedures planned for my horse. I agree that I will notify the insurer.

Signature of Owner/Agent _____

Date _____

Printed Name _____