MuraBella ANIMAL HOSPITAL

3625 Pacetti Road St. Augustine, FL 32092
(904) 940-9401

Caregiver Authorization Form*

Pet Name(s) _____

Owner or Co-Owner Name: _____

Address: _____

Best Phone Number(s): _____

I authorize the person(s) named below ("caregiver") to authorize treatment of my pet in my absence. The caregiver can approve estimates, authorize treatments up to and including euthanasia (if recommended by doctor). Caregivers can approve on-going treatments including transferring to emergency facilities or hospitalization if deemed medically necessary by the doctor. I understand MuraBella Animal Hospital will attempt to contact me during any emergency situation but hereby authorize the caregivers named below to authorize treatments deemed necessary by the doctor. *I understand the charges are my responsibility and will be billed to the credit card on file.

Caregiver Name 1 (as it appears on Driver's License): _____
Best Phone: _____

Caregiver Name 2 (as it appears on Driver's License): _____
Best Phone: _____

Caregiver Name 3 (as it appears on Driver's License): _____
Best Phone: _____

Critical Care Authorization

If your pet is presented in a **critical or life threatening** state **in your absence** and in order to prevent incorrect assumptions and miscommunications we require authorization to initiate and/or continue acute care to attempt to stabilize your pet, as well as obtain your acceptance of financial responsibility for the care. Critical Care Treatment can include CPR (Cardio Pulmonary Resuscitation), IV catheter placement, fluid therapy and blood products, treatment, medications, blood chemistry analysis, in-house ultrasound, radiographs or other diagnostic tools.

"I am the owner for the pet(s) listed above and in my absence **I authorize the person(s) named above** to initiate, approve estimates, treatments, prescriptions deemed medically necessary based on doctor recommendations **including but limited to emergency and critical care situations."** *

I hereby Authorize ☐ **No More Than $500 (Stabilization)** ☐ **Based on Doctor's Recommendations**

Owner **or** Co-Owner Name _____ Date _____

Owner **or** Co-Owner Signature _____

* In order to not delay care of your family member, a **Payment Authorization Form** is also required to be kept on file.