



**VCA Main Street Animal Hospital**

2773 Main Street  
San Diego, CA 92113  
(619)232-7401

Doctor: Robert Tugend DVM • Date: 02/09/2010 at 5:08PM • Trmnt Plan/Estimate: 103393-117133

Client		Patient	
Name:	Southern Ca Ger. Shep. Rescue	Acct. No:	14468
Address:	6161 El Cajon Blvd. #460 San Diego, CA 92115	Name:	Bailey
		Species:	Canine
		Breed:	Shepherd Dog, German
		Color:	Black And Tan
		No:	28921
		Sex:	Female Neut.
		Birth:	07/20/2009
		Weight:	1.3 lbs

Detailed Information					
Date	Description	Quantity	Price	Tax	Total Price
02/09/2010	Exam/Consultation	1	47.50		47.50
	Pelvis I View	1	143.10		143.10
	Fluid Set Up - Surgery	1	73.25		73.25
	--IV Cath. Sx Included	1	0.00		0.00
	--IV Admin.-Sx Included	1	0.00		0.00
	--Fluid 1st Bag-Sx Incl	1	0.00		0.00
	Hospitalization	1	99.85		99.85
	--Occupancy	1	0.00		0.00
	--Nursing Care Included	1	0.00		0.00
	--Prof. Care Included	1	0.00		0.00
	Nursing/Injections	3	56.70		56.70
	Injectable Cefazolin	4	23.36		23.36
	Injectable Morphine	3	26.30		26.30
	Amoxi/Clav 375mg	14	44.21		44.21
	Tramadol 50mg (gen)	12	15.33		15.33
	--Exam Preanesthesia In	1	0.00		0.00
	Preanesthes./Induction	1	60.20		60.20
	Gen.Anes. 1st 1/2 Hr.	1	123.35		123.35
	Gen.Anes. Add. 15 min.	1	55.45		55.45
	Anes. Monitoring Lv2	1	65.75		65.75
	Femoral H&N Osteotomy:2	1	1192.60		1192.60
	Biohazard Waste Mgmt.	1	4.99		4.99
	Rad. Follow-up Study	1	110.70		110.70
<b>Subtotal:</b>					<b>\$2,142.64</b>

**Please read, complete and sign this form**

THIS TREATMENT PLAN AND ESTIMATE MAY RANGE FROM: \$2143.00 To \$2678.00

Client's Initials

\*\*\*\*\*  
\* AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT \*  
\*\*\*\*\*

I, the undersigned, certify that I am the owner, or authorized agent for the owner, of the animal, "Bailey". I authorize the doctor on duty and assistants to perform the procedures listed in the above treatment plan and estimate, including administration of pain relief medications, sedatives and/or anesthetics, as well as any necessary and appropriate medical, radiological, surgical, nursing, diagnostic and/or emergency care for Bailey. I have been advised as to the nature of the procedures and the potential risks, and I understand the reason why such medical and/or surgical treatment is considered necessary, as well as its advantages, and possible complications, if any. I also understand that no guarantee of successful

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Please read, complete and sign this form - Continued

treatment can be made.

In some cases it is impossible to accurately estimate the total charges involved because the total extent of the injuries or illness may not be immediately apparent. The results of blood tests, urinalysis, radiographs, etc. may be needed before the doctor can approximate a total expense. Additionally, it is impossible to accurately estimate the time an individual animal needs to respond to a treatment plan and this factor will affect the total cost. It is understood that these are estimated fees.

If additional treatment is needed that exceeds the estimated range, the hospital will contact me with an updated treatment plan and estimate to obtain my permission to proceed, and I will increase my deposit accordingly. In the event that any urgent care requirements arise and the hospital makes a reasonable attempt but is not able to contact me, I grant permission to render to Bailey whatever emergency and life-stabilizing treatments are deemed necessary by hospital personnel and agree to pay for these emergency and life-stabilizing treatments even if they exceed this estimate.

I understand that prices on this treatment plan and estimate are valid for 30 days from the document date.

A MINIMUM DEPOSIT OF 50.00% OF THE ESTIMATE IS REQUIRED: \$1071.00

I assume full financial responsibility for all charges and services incurred to Bailey while in the hospital and agree to pay all such charges at the time of release of such patient.

I hereby certify that I have read and fully understand this authorization for medical and/or surgical treatment.

Signature of Owner or Responsible Agent
(Must be over 18 years of age)

Date

Signature of Hospital Employee

When did your pet last eat?: (Time / Day)

Phone numbers where you can be reached today (Note times if applicable):

Home: Work:
Cell: Pager/Other:

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Summary			
Patient Name	Total Price	Total Tax	Total Due
Bailey	2,142.64		2,142.64
Cash:		0.00	
Check:		0.00	<b>Total Due:</b> 2,142.64
Credit Card:		0.00	<b>Amount Paid:</b> 0.00
			<b>Amount Due:</b> 2,142.64

Thank You: Andrea S.

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