ESTIMATE ONLY -- NOT A BILL

University of Wisconsin - Madison
UW Veterinary Care
2015 Linden Drive
Madison, WI 53706
608-263-7600 or 1-800-DVM-VMTH
http://uwveterinarycare.wisc.edu

KOTOYO HOSHINA
5002 SHEBOYGAN AVE
APT 120
MADISON, WI 53705

Date: 09/14/11

Account: 137820

Patient: Mango	MR#: 123074	Estimate Range	
	ANESTHESIA		
01318	S.S. Mask 1/2 hour 5-75kg	33.20	43.16
	CLINICAL PATHOLOGY		
03113	Bone Marrow	54.00	70.20
	BILLABLE PROCEDURES		
90021	Bone Marrow Aspirate/Bone Core	74.50	96.85
	Estimate Total:	**161.70**	**210.21**
	Current Balance:		**25.80**
	Estimate + Current Balance:	**187.50**	**236.01**
	50% Deposit Required:		**130.91**

*This estimate is based upon the initial examination of your animal by the clinician below and may change as diagnostic and therapeutic procedures deem necessary. Following the initial exam by a clinician, a deposit of 50% of the high estimate must be made before further procedures are initiated. Upon discharge, the charges are to be paid in full. Please contact the billing desk at 608-263-7600 if you have any questions.
UNPOSTED FEES: In some instances, charges for services rendered may still be in the processing stage when you pick up your animal. The client agrees to pay for these services when a bill is received.

Doctor/Technician: _____

Client Acknowledgement: Kotoyo Hoshina Date: 9/14/2011

VETERINARY MEDICAL TEACHING HOSPITAL
University of Wisconsin - School of Veterinary Medicine
2015 Linden Drive, Madison, WI 53706
Phone: (608)-263-7600, 800-386-8684, Fax:(608)-265-8276

Medrec #:	123074	**Owner:**	Kotoyo Hoshina	**Date:**	09/14/11
Patient:	Mango	**Address:**	5002 Sheboygan Ave	**RDVM:**	
Visit ID:	1126064		Madison, WI 53705	**Service:**	SA-Special Species
Species:	Lapine	**Home Phone:**	(608) 334-5123	**Clinician:**	D. Keller, DVM, PhD
Breed:	Other Lapine (Rabbit)	**Work Phone:**	-		
Color:	Red/White	**Cell Phone:**	-		

I am the owner or authorized agent of the above described animal/herd/flock and have the authority to execute this document.

RECOMMENDED PROCEDURES
I hereby authorize agents of the University of Wisconsin-Madison School of Veterinary Medicine to perform **the following procedures(s) or treatment(s)** upon my animal(s): Genaral anesthesia, bone marrow aspirate, cytology of aspirate.

MAJOR RISKS
The nature and purpose of these procedures and treatments, and available standard of care treatments, have been explained to me. I understand **the major risks** listed below associated with these procedures and treatments that I am authorizing. I consent to the administration of sedatives and anesthetic agents as deemed appropriate by the veterinarian in charge. Adverse reaction to anesthesia, bruising or hemorrhage at site of bone marrow collection

RESUSCITATION (Client/agent must initial one)
In the event my animal suffers cardiac arrest:
_____ I request that CPR (cardiopulmonary resuscitation) **NOT** be performed
_____ Closed chest CPR to be performed
_____ Open chest CPR to be performed

COMPLICATIONS & STATEMENT OF NO GUARANTEE
If unforeseen conditions arise which in the judgement of the attending veterinarian call for procedures or treatments other than those now being authorized, I authorize such procedures or treatments if reasonable efforts to contact me for further consent are unsuccessful. I acknowledge that no guarantee has been made of the described procedures and that complications may arise.

STUDENT PARTICIPATION
I understand that students at the School of Veterinary Medicine will be present and participate in performing the procedures and treatments under supervision that I have authorized.

RESIDUAL BLOOD or TISSUE SAMPLES
Any remaining blood or tissue samples obtained from my animal during planned procedures / treatments may be utilized by the Veterinary Medical Teaching Hospital for future research.
_____ Initial here to **decline** the use of samples from my pet for future research

PHOTOGRAPHY and VIDEO IMAGING
By consenting to the provision of medical and surgical services at the Veterinary Medical Teaching Hospital, I also agree to permit photographs or videotapes to be taken of my animal. I agree to have my visit videotaped for teaching purposes. I will be informed of any interactions between myself and the student and/or veterinarian that are videotaped. The photographs may be taken for the purpose of diagnosis, treatment, teaching students, inclusion in scientific publications, or publicity. Identifying information will be included only for purposes of direct patient care.
_____ Initial here to **decline** use of photographs / videos of my animal other than direct patient care

FINANCIAL RESPONSIBILITY
I acknowledge that I am financially responsible for the veterinary medical care described above, as well as any additional care necessitated by known or unforeseen complications.

AUTHORIZATION

Clinician Name: _____ Date: _____

Signed: Kotoyo Hoshina Date: 9/14/2011
(Owner or authorized agent of owner)

If someone other than the animal's owner is signing this authorization, provide the additional information:
Print name: _____ Relationship to owner: _____
Address: _____