MIAMI SPRINGS ANIMAL HOSPITAL
9 Westward Drive, Miami Springs, FL 33166
Tel: (305) 885-2000 / email: miamispringsanimalh@gmail.com

HEALTH CARE PLAN

Name____
Last First Middle Initial

Address____
Street City, State, Zip Code

Phone No.___________________________Emergency No.______________________________

Pet name____

Birth Date____

Species: Cat________ Dog_________

Breed____ Sex__________

BENEFIT OF THE HEALTH CARE PLAN

All office visits are reduced to $10.85. The plan includes all vaccinations. All in-house laboratory work is reduced by 50%. All medical service fees are reduced by 20%. These discounts apply to services of the Miami Springs Animal Hospital such as bathing, x-rays, de-worming, anesthesia, surgery and dentistry. Monthly heartworm, preventatives prescribed medications and over the counter products are discounted 10%. All pets are eligible for enrollment in the program at any time or for Annual or Semi- Annual scheduled vaccinations.

HEALTH CARE PLAN

ANNUAL CANINE MEMBERSHIP $139.00
ANNUAL FELINE MEMBERSHIP $129.00
FIRST YEAR PUPPY/KITTEN MEMBERSHIP $189.00
FIRST YEAR PUPPY/KITTEN WITH SPAY/NEUTER $289.00***
***(UNDER 25LBS DOES NOT INCLUDE MEDICATIONS OR BLOOD WORK)
Some restrictions may apply

ANNUAL CANINE Dr. Examination $10.85(*)
Vaccinations for Distemper, Hepatitis, Parainfluenza, Parvovirus, Bordetella, Leptospirosis and Rabies (*)

ANNUAL FELINE Dr. Examination $10.85(*)
Vaccinations for Distemper, Rhino-Calici (FVRCP), Chlamydia and Rabies.

6-MONTH CANINE BOOSTERS Dr. Examination $10.85(*)
Vaccinations for Parvovirus, Coronavirus and Bordetella.

PUPPY VISIT #1-2 Dr. Examination $10.85(*)
Vaccinations for Distemper, Hepatitis, Parainfluenza, Paravovirus (DA2PP), and Bordetella.

PUPPY VISIT #3-4 Dr. Examination $10.85(*)
Vaccinations for Distemper, Hepatitis, Parainfluenza, Paravovirus (DA2PP), Leptospirosis, and Rabies with the last set. (*)

KITTEN VISIT #1-2 Dr. Examination $10.85(*)
Vaccinations for Distemper, Rhino-Calici (FVRVP), and Chlamydia.

KITTEN VISIT #3- 4 Dr. Examination $10.85(*)
Vaccinations for Distemper, Rhino-Calici (FVRCP), Chlamydia and Rabies.

LABORATORY FEES 50% OFF

Fecal (microscopic parasite) Exam
Urinalysis
Ear Cytology
Heartworm Test
Giardia Test
Parvo Snap Test
Radiology
Skin Scraping
All in-House Lab-Fees 50% off

100% OFF VACCINES

20% OFF SURGICAL SERVICES
20% OFF DENTAL CLEANING** (**Cannot combine with specials)

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*OSHA regulations require the proper disposal of bio hazardous wastes. This includes the disposal of any syringes.

A $5.95 charge will be applied when bio hazardous waste is generated.

*County Licenses and registration are not included in the cost of vaccination and is the responsibility of the pet owner.

*$20.00 record transfer change will be applied

Services that are not covered are:

- After Hours Emergency Care
- Specialist Referral
- County Licenses (Rabies Tag, Health Certificates)
- Prescription food Diets
- Feline Leukemia/FIV Test
- Leptospirosis Vaccine

THE HEALTH CARE membership is NOT TRANSFERABLE from one pet to another, but can be transferred in the case of a new ownership. **THE HEALTH CARE PLAN IS NOT REFUNDABLE**.
Please make appointment to schedule routine visits and non-emergency visit in order for us to serve you better. The hours of operations are as follow.

MONDAY to FRIDAY	**9 am – 6 pm**
SATURDAY	**9 am – 4pm**
SUNDAY	**CLOSED**

I hereby authorize the veterinarian and his/her assistance to examine, prescribe for, or treat the above described pet(s). I assume responsibility for all charges incurred in the care of this animal. The nature of such services has been described to me, to my satisfaction, and I expect all procedures to be done to the best abilities of the professional staff. I understand that there is no guarantee or warrantee that can be ethically or professionally made regarding results or cures. I also understand that I will not receive a refund on any type of medication and/or vitamins. I agree that all charges will be paid in full at the time of provided services. Full payment shall be required before any surgical procedure.

Signature of Owner or Agent

____ Date________________________

Method of payment: [Cash] [Check] [MC/VISA] [Discover] [AMEX] [CARE CREDIT]