ESTIMATE FOR SERVICES

Animal Care Center of Plainfield

14411 S. Rt. 59
Plainfield, IL 60544
815-436-8387

Date: 1/2/2019

Estimate 1/2/2019 4:35 PM

RESCUE SMALL PAWS **Account: 105043** **Phone: (918) 638-5854** **Patient: Emmie**

Code	Service/Item	Qty	Amount
RAD	Radiographs 2 view	1.00	160.00
	Organization Discount 10%: 10%		
310	Radiograph Each Addtl View	1.00	42.00
	Organization Discount 10%: 10%		
2192	Fluids (Intravenous) Per Day	1.00 - 2.00	83.05-166.10
	Organization Discount 10%: 10%		
MEDK9_BD	Boarding Canine Medical	1.00	50.00
	Organization Discount 10%: 10%		
1868	Ampicillin Injectable	3.00	90.40
	Organization Discount 10%: 10%		
1518	Cefpodoxime 100 mg	7.00	15.58
	Organization Discount 10%: 10%		
1267	Vetprofen 25mg	14.00	15.58
1569	Laceration Repair	1.00	150.00
	Organization Discount 10%: 10%		
BUHOS	Buprenorphine inj-hosp	1.00	53.55
	Organization Discount 10%: 10%		
INVBUP	Buprenorphine - inventory control	1.00	0.00
	Organization Discount 10%: 10%		
98743	Additional Inj- Non Controlled	2.00	34.34
	Organization Discount 10%: 10%		
ORG37	HOSPITALIZATION/DAY-ORG	1.00 - 2.00	20.00-40.00
HOSL2	ER-HOSPITALIZATION L2	1.00 - 2.00	87.00-174.00
124	ER-AMPICILLIN INJECTION	1.00	37.00
354A	ER-BUPRENORPHINE INJECTION	1.00	67.00
2051	ER-FLUID PUMP	1.00 - 2.00	30.00-60.00
1	Office Visit	1.00	45.00
	Organization Discount 10%: 10%		
BIO	BIOHAZARD DISPOSAL FEE	1.00	2.25
501	Hospitalization (Per Day)	1.00 - 2.00	43.51-87.02
	Organization Discount 10%: 10%		

Estimate Total:	**1026.26 - 1289.82**
Discounts:	**76.75 - 89.40**
Net Total:	**$949.51 - $1,200.42**

THIS IS ONLY AN ESTIMATE AND REFLECTS THE FIRST 24 HOURS OF TREATMENT.

The actual treatment plan may require more diagnostics, medications or procedures. This estimate is not a representation of the final bill. In addition, when medically necessary, hospital stays require certain vaccines and tests that can cost up to $160.
THE FINAL BILL WILL BE COLLECTED UPON DISCHARGE

I have read and do understand this estimate.

Signed:_____
Date:_____

I DECLINE THIS RECOMMENDED TREATMENT PLAN:

Signed:_____
Date:_____

-AUTHORIZATION OF ADDITIONAL TREATMENT PER DAY-

I take full responsiblity for any charges that may accrue after my intial deposit is made. I am aware that additional charges will be added to my bill and will be due in full at the time of pick up.
Someone will be in contact each day to discuss a new estimate/treatment plan for each additional day of my pet's care.

Signed: _____
