

CONSENT FORM

LUCKNOW PLASTIC SURGERY

CAPITAL DIAGNOSTICS, M2 Gole Market, Mahanagar, Lucknow, 226006, INDIA

Tel: - 91-522-2384881 / 2380550

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

I _____ resident of _____ hereby authorize Dr. Surajit Bhattacharya. (And whomsoever he may designate as his assistants/ colleagues/ nurses/ technicians etc.) To administer such treatment as necessary, and to perform the following operation/procedure _____ and such additional operations/biopsies/procedures as are considered therapeutically or diagnostically necessary during the course of the above mentioned operation/ procedure/ treatment. I also authorize the doctors to perform the above procedures at Ajanta Hospital or any other alternative Medical set up as deemed appropriate by them.

I have been explained that during hospitalization my patient will be administered drugs orally, intravenously or by any other route as is required. IV infusions, blood transfusions etc. may be required. The risks of any of the above could be minor/major/severe reactions with serious/fatal consequences.

I have also been explained that facilities better than here may be available at other places to deal with emergencies arising out of these situations or arising out of the disease itself.

I also consent to the administration of such anesthetic as are considered necessary for any of these purposes at my own risk. Any tissues or parts surgically removed may be disposed off by treating doctors in accordance with accustomed practice.

I also certify that no guarantee or assurance has been made as to the result that may be obtained. I am fully aware that any treatment/procedure, including the ones that I have to undergo has a risk of actual failure, and/or additionally a risk of limiting my functions, or of incapacitating me and besides a true possibility of mortality/ actual death. I am also aware that in the field of medicine, other unforeseen risks or complications not discussed may occur.

I also undertake to pay in full the professional fee/ hospital bills etc. that are due to me. I understand that payments to my treating doctors are solely for carrying out the procedures, and absolve them of any liability arising to me owing to my absence from work.

I also undertake that I am not withholding any relevant information that my doctors may need for proper conduct of treatment.

I hereby also grant permission and consent for the taking of and publication of photographs for academic activities, for having medical/para-medical visitors in the operating room during my surgery and for the use of tissue grafts or implants.

I have been given the opportunity to ask any questions regarding above which I wanted to ask and have received answers to my satisfaction.

Signatures of Witness _____ Signatures of Patient _____ Signatures of Patient _____ Signatures of Patient _____ Signatures of Patient _____
of Patient

Date _____

AJANTA HOSPITAL

LUCKNOW PLASTIC SURGERY

CAPITAL DIAGNOSTICS, M2 Gole Market, Mahanagar, Lucknow, 226006, INDIA

Tel: - 91-522-2384881 / 2380550

Part 2 Consent (for Foreign or Non Resident Patients.)

I agree that the relationship between myself and Dr. Surajit Bhattacharya shall be governed by the law, and construed in accordance with the laws of the State of Uttar Pradesh and India. Also, I acknowledge that the treatment/service was performed in the State of Uttar Pradesh and that the Courts of the State of Uttar Pradesh alone shall have jurisdiction to entertain any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of treatment. The patient hereby agrees that he/she will commence any such legal proceedings in the State of Uttar Pradesh and only in the State of Uttar Pradesh and hereby submits to the jurisdiction of the Courts of the State of Uttar Pradesh, India.

The patient also agrees to ask for, by way of financial compensation, if at all, an amount equivalent to only the medical expenses paid at the Hospital, and nothing more, either by way of other expenses incurred directly or indirectly for the present treatment, or by way of personal compensations for any deemed losses.

I also give an undertaking that I have a valid passport and that there are no pending legal actions against me either in my own country or elsewhere.

Witness _____ aaaaaaaaaaaaaaaaaa Patient _____

Country of Origin

Passport Number (Copy of passport to be attached)