PATIENT CONSENT FORM FOR TREATMENT

Patient ID:

I,.....
Age……. Gender…….. Address
.....
.....
..... hereby authorize CareNcomfort and whomsoever they may designate as staff members to administer care as necessary, for the following procedure/treatments

1
2
3
4

and such additional treatments/intervention found necessary for the patient during the course of above mentioned procedure

I hereby authorize CareNcomfort Staff to perform the above procedures at my home or at the alternative medical set-up found suitable by them. I hereby grant permission to store necessary medical data in the format of secure electronic medical records (EMR). If necessary, the summary or anonymize versions of this data may be later shared with third parties.

I agree that as long as I am a patient of CareNComfort, I may be administered with medications prescribed by my doctor through oral or other routes of administration as it is required in the supervision of family members/relatives.

I understand that guarantees or assurances cannot be made as to the outcome of procedure/treatment that I may receive or to the result that may be obtained. I also certify that no similar guarantees are made towards my treatments or procedures.

I understand that medical staff is duly appointed to clinically take care of me. And non-medical or other household, personal tasks of other family members will not be given to them.

I will maintain proper conduct throughout the process and shall not with-hold any information relevant for my treatment/procedure.

I hereby disclose that I have asked and cleared all my concerns pertaining to above mentioned details. I was given opportunity to share my concerns and I received answers to my full satisfaction.

(sign)