MORAYA MULTISPECIALITY CHARITABLE HOSPITAL

Operated by Ashwin Medical Foundation

Power House Chowk, Chinchwad, Pune – 411033
Phone: 020-67306500 | Hospital Services: 24/7

PATIENT CONSENT & DECLARATION FORM

1. PATIENT DETAILS

Patient Name: _____

Age: _____ Gender: _____

UHID / Registration No.: _____

OPD / IPD No.: _____

Mobile No.: _____

Date: _____

2. PATIENT DECLARATION & CONSENT

I hereby acknowledge and agree that:

1. I have voluntarily approached Moraya Multispeciality Charitable Hospital for medical consultation, examination, investigation, and/or treatment.
2. I understand that the hospital operates 24 hours a day, 7 days a week, while individual doctors' consultation and OPD timings are subject to availability and schedules.
3. I understand that the hospital publishes a PDF directory of its consulting doctors, including their qualifications, degrees, specializations, and available registration details.
4. I consent to medical examination, routine investigations, and treatment as explained by my treating doctor. I understand that specific procedures, surgery, anesthesia, and other interventions requiring separate informed consent will be covered by separate consent forms.

5. I confirm that I have provided accurate information regarding my medical history and health condition to the best of my knowledge.
6. I understand that my personal and medical information may be collected, maintained, and used for treatment, diagnosis, hospital administration, billing, insurance, and legal requirements, in accordance with the hospital's Privacy Policy and applicable laws.
7. I understand that medical treatment involves certain risks and that no specific medical outcome can be guaranteed.
8. I have had the opportunity to ask questions and understand the information provided to me. I voluntarily give my consent for the above purposes.

3. FINANCIAL ACKNOWLEDGEMENT

I understand that applicable hospital charges, investigations, medicines and treatment expenses will be payable as per hospital policy. Charitable concessions, where applicable, are subject to eligibility and approval.

4. PATIENT/AUTHORIZED REPRESENTATIVE

Name: _____

Relationship with Patient (if applicable): _____

Signature / Thumb Impression: _____

Date: _____ Time: _____

5. DOCTOR / HOSPITAL REPRESENTATIVE

Name: _____

Designation: _____

Signature: _____

Date: _____

IMPORTANT: This form is a general consent and acknowledgement. It does not replace procedure-specific informed consent where required. In

emergencies, treatment will be provided in accordance with applicable law and accepted medical standards.