

Consent Form

To

Star Hospitals,
Health Care consultation center.
31,Hameedia Centre, 1st floor, Haddows road, Nungambakkam
Chennai – 600034, India

Re: Treatment facility to be availed by me/ us/my child.

As agreed by me / us, I/We Holder of passport of
passport number.....give full consent to avail treatment
through Star hospitals ,I/We will be availing the treatment facility at
.....Hospital.

I/We fully understand that the quote given by the healthcare facilitator is only an approximate amount and not the final estimate for my/our treatment. I/We hereby confirm and commit that in the event of cross referral or additional diagnostic or treatment facility availed by me / us, or any charges for services utilized by me/us and reflected in the final invoice over and above the Estimated Costs as per the given estimate letter, I/ we shall pay the Said Hospital(s) the expenses thereof before leaving against medical advise or getting discharged from the Hospital.

I/We agree and acknowledge that the.....Hospital or the Healthcare Facilitator has made no direct solicitation or other representation to me/ us for the provision of medical services in the territory where I/We ordinarily reside or carry on business.

I/We agree and understand that the Courts in, alone shall have exclusive jurisdiction to try all claims of medical negligence in provision of medical services, that are directly attributable to the act or omission of the Hospital or the Healthcare Facilitator, its employees, or its duly appointed representative, (hereinafter, “the said Claims”). No other action or claim except under the said Claims shall lie against the. Hospital or the Healthcare Facilitator.

I/We agree and understand that upon arrival at..... Hospital, the patient shall be thoroughly examined by the Doctor(s) at..... Hospital. The surgery/ procedure would be performed, refused, or modified, depending upon the Patient’s condition at that time and if the surgery/ procedure cannot be performed due to patient’s condition, the patient shall return to his/her country at his/ her own expense/ cost. I /We understand that I/We shall be entitled to recover the advance from the Hospital after deduction of the preliminary treatment or investigations carried out if any. In no event shall the..... Hospital or the Healthcare Facilitator is

responsible for any costs, claims and consequences arising out of such eventuality.

I /we fully understand and agree that “Star hospitals” is only a Healthcare facilitator and do not decide/advise or carry out any form of treatment. Star hospital is also not responsible for any untoward happenings that may occur during or after the treatment.

I / We hereby undertake and agree that I/ we, our companions shall abide by all rules, regulations, formalities including submissions / execution of any and all forms of the Hospital and also do not infringe any laws of----- during the period of treatment.

I/We agree and understand that HCF shall not be in any manner responsible or liable, (i) to repay the dues for any treatment facility availed or to be availed by me / us; and/ or (ii) for any outcome or result of any treatment or surgery or for any advice given / to be given by the-----Hospital; and (iii) for I/ my/ or we our companions not abiding by any rules and regulations of theHospital or infringing any laws of.during the period of treatment.

Yours truly,

Patient’s Signature

Parent’s /Guardian’s Signature

Name

Address & Ph.no

Witness 1:

Witness 2:

Signature:

Signature:

Relationship to the patient

Relationship to the patient

Full Name

Full Name

Contact Details

Contact Details