INDIA HOME CARE MEDICINE

BRANCHES : NAGPUR & KOLHAPUR

CONSENT FORM FOR ANNUAL MEDICAL CONTRACT FOR YOUR PARENT[S] IN Rs. 12,222/- ONLY

(To be filled by Close Relative/ Patient)

I came to know about your India Home Care Medicine Services from [Write Here The Source] : e.g. Newspaper/ _____.

I am willing to register my Father/Mother/Any Other [Please Specify] _____

Mr./Mrs./Ms. [Full Name] : _____ aged about _____ Yrs. He/She is suffering from [Main Diseases] _____.

I am paying Rs. 12,222/- by NEFT/Cash/Cheque _____ for Activation of the Annual Medical Home Health Contract Plan from Dated _____ to Dated _____.

I am providing a xerox copy of Aadhar Card along with a Passport Photo. I know the details of services which will be given for above period under this plan. I also know that I will have to do Extra Payment for whenever he/she requires other medical services like Ambulance for Admission/Investigations/Treatment or Additional Visit of IHCM Doctor or Any Other Consultants that may be required other than this plan [SOS].

This Plan Consists of Following Services [SUNDAY IS HOLIDAY FOR OUR SERVISES] :-

- Monthly Home Visit of Physician x 12 Visits between 9 a.m. to 7 p.m. on Weekdays.
- Monthly Home Visit of Nurse x 24 Visits (This visit follows after 2 weeks of Doctor Visit) between 9 a.m. to 7 p.m. on Weekdays.
- Complimentary Check-Up in Home at the Start of Plan : This includes ECG, B.P., Hb%, Fasting & Postmeal Sugar, Sr. Creatinine, Sr. Cholesterol, Urine : RE, Test for Microalbumin, Combur 10 test, Stool : Occult Blood & RE, Other Clinical Examinations like Height & Weight, Consultation, 3 doses of T.d. Vaccination [In first 6 months] etc. all at the COMFORT of your home as per your convenience.

Please Fill The Following :

- ARE YOU REACTIVATING THIS PLAN ? Yes [ ] / No - Availing for 1st time [ ]
- If Yes then please state the reasons of Reactivation : _____

_____ If Yes then please also state your suggestions to improve our Home Health Services : [You can use a separate sheet of paper for writing Suggestions/Complaints etc.] _____

_____

I have understood that in this plan there is NO PROVISION for EMERGENCY HOME VISIT or NIGHT VISIT. Doctor will not attend my patient whenever I want or as per my wish, this I have understood. As per this plan visits will be done only on the decided dates and time.

THANKS INDEED ! HELP US TO SERVE ELDERS !!

Patient's Signature [OR] Thumb Impression

Receptionist's Name & Signature

Name & Signature [To be filled by Authorized Person]

Date : _____ M. No. _____ Landline No. _____

Postal Address for Home Visit : _____

_____

Email Address for Communication : _____