INDIA HOME CARE MEDICINE [TOLL FREE NO. 1800 102 3817]

BRANCHES : NAGPUR, PUNE & KOLHAPUR

CONSENT FORM FOR ANNUAL MEDICAL CONTRACT FOR YOUR PARENT[S]

IN Rs. 11,111/- ONLY FROM 01/04/2017

(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. 11,111/- 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].

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

- Monthly Home Visit of Physician x 12 Visits between 9 a.m. to 7 p.m. on Weekdays.
- Monthly Home Visit of Nurse x 12 Visits (This visit follows after 2 weeks of Doctor Visit) between 9 a.m. to 7 p.m. on Weekdays.
- <u>Complimentary Check-Up in Home at the Start of Plan :</u> 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.

<u>Please Fill The Following :</u>

- 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.] _____

_____

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 : _____

This form is updated on 01/04/2017