



Ahalia Diabetes Hospital

Ahalia Campus, Palakkad - 678557 www.ahaliadiabetes.org ☎ 04923 225 555 ☎ 94 96 006 739

FINANCIAL CONSENT

DATE:

AGE/SEX

NAME OF THE PATIENT:

Name of the Bystander:

MR. No.:

Relationship:

DOCTOR'S NAME:

DEPARTMENT:

Diagnosis/ Procedure/ Treatment Name:	
Approximate Hospital stay (In days):	
Approximate Treatment Expense:	

ROOM RENT	GENERAL WARD	1000* _____ DAYS	
	NON-AC ROOM	1800* _____ DAYS	
	AC ROOM	2800* _____ DAYS	
	DELUX ROOM	4000* _____ DAYS	

INCLUSIONS: Room Rent, Procedure Charge, Professional Fees.

EXCLUSIONS: Pharmacy, Diagnostic Procedures (Laboratory and Radiology), Cross Consultations, if any. If the length of stay extended beyond the expected days.

I have been clearly explained regarding the matter mentioned above and I am hereby giving my known consent for the treatment advised.

Name:

Procedure Explained by:

Address:

Signature:

Contact number:

Signature:

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