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| NAME: {NAME}  AGE: {AGE}  SEX: {SEX}  ADDRESS:{ADDRESS}  CONTACT NO.: {CONTACT}  CONSULTANT: {DOC}  DIAGNOSIS: {DIAGNOSIS} | REG. NO.: {REGNO}  QUALIFICATION: {QUAL}  OCCUPATION: {OCCUP}  MARITAL STATUS: {MARITIAL}  DATE OF BIRTH: {DOB}  EMAIL I.D.: {EMAIL}  CASE TAKEN BY: {CASEBY}  REFERRED BY: {REFERRED}  DATE: {DATE} |

1. **I authorize the Homoeopathic treatment to be commenced for me, under the direction of Dr. Rajan Dubey.**
2. **I have been explained the exact mode of treatment, alternative therapies, advantages and disadvantage of reach of them, benefits, implications, consequences and sequelae of the treatment. I consent to this treatment of my own free act and will.**
3. **After asking questions and satisfying myself, I have decided to consent for the treatment.**
4. **I have been explained that the management of the case will be done by a team of Doctors.**
5. **I state that no guarantee of results or cure has been given to me.**
6. **I consent to be observation, photography of the patient for medical, scientific, educational purposes provided that due care is taken to conceal the patient's identity.**
7. **I undertake to comply with all the instructions given to me (verbal & written) during the treatment.**
8. **I am aware that past illness can get aggravated and recovery from the same has been explained to me.**
9. **The treatment of mentally & physically challenged children is aimed at enabling them to lead an independent life as far as possible.**