Medical Treatment Consent Form

This Consent Form is made on this 26th day of September, 2025, at Bangalore, Karnataka.

Between

Patient Name: Mr. Rajesh Kumar, S/o. Mr. Ramesh Kumar, aged 45 years, residing at No. 12, MG Road, Bangalore – 560001.
(Hereinafter referred to as the *"Patient"*, which term shall, unless repugnant to the context, mean and include his heirs, legal representatives, administrators, and assigns).

And

Hospital Name: City Care Multispeciality Hospital, having its registered office at No. 25, Residency Road, Bangalore – 560025, represented herein by Dr. Anita Sharma, Senior Surgeon.
(Hereinafter referred to as the *"Hospital/Doctor"*).

1. Purpose of the Consent

The Patient acknowledges that he has been advised to undergo **Gallbladder Removal Surgery (Cholecystectomy)** by Dr. Anita Sharma at City Care Hospital.

2. Information Provided

The Patient confirms that:
a) The nature of the procedure, possible risks, complications, and expected benefits have been explained.
b) Alternative treatment options have been discussed.
c) No guarantee has been given regarding the success of the treatment.

3. Consent

The Patient hereby voluntarily consents to:

- Undergo the above-mentioned surgery.
- Administration of anesthesia as necessary.
- Any additional or emergency procedures found necessary during the course of treatment.

4. Acknowledgment

The Patient understands that:

- Medical and surgical procedures carry inherent risks including, but not limited to, infection, bleeding, and adverse reactions.
- The Hospital/Doctor shall not be held liable for consequences arising from unavoidable medical risks.

5. Confidentiality

The Hospital agrees to maintain confidentiality of the Patient's medical records in accordance with applicable Indian laws, except when disclosure is required by law.

6. Jurisdiction

This Agreement shall be governed by and construed in accordance with the laws of India. The courts at Bangalore shall have exclusive jurisdiction.

Signatures

Patient/Guardian: _____
(Name & Signature)

Doctor: _____
(Name & Signature)

Witness 1: _____

Witness 2: _____