ISO 9001:2008 CERTIFIED
DAKKS & NABCB ACCREDITED

Dr L H Hiranandani Hospital

Your Family Superspeciality Hospital

A NABH Accredited Hospital

(National Accrediation Board for Hospitals & Healthcare Providers. An Initiative of Quality Council of India)

Winner of IMC Ramkrishna Bajaj National Quality Trophy, 2008

India's first Hospital to get the International Asia Pacific Quality Award 2009

Hiranandani Hospital

Registration

*Ms / Mr / Master / Baby of / Baby _____

First name Middle Name Last Name

MR NO.: _____ IP NO.: _____ Date: _____

Parent's / Guardian / Spouse Name: _____

Date of Birth* :_____ Sex*:_____ Blood Group* _____ Language:_____

Nationality : _____ Marital Status* :_____

Phone : Resi.: _____ Off.: _____ Mobile :_____

Email : _____ Occupation: _____

Address : _____

_____

_____ *State _____ *Country _____

Allergy Medicine* : _____ ☐ Not Known Allergy of Food Item* : _____ ☐ Not Known

Treating Doctor _____

Referred by Dr. / Mr. / Ms. _____

Emergency Contact Person Name * : _____

Relationship* _____ Tel. No. of Emergency Contact Person* : _____

General Consent

I/We understand that my this admission medical record shall be destroyed by hospital after 5 years of my discharge.
I/We agree for the patient to undergo examination, investigation and treatment as decided by the treating doctor/ hospital and also to abide by its schedule of charges, rules and regulations (available at registration counter)
If any surgical procedures have to be performed, a separate Informed Consent shall be taken.
I authorise Mr/Mrs._____to take decision on my behalf in case of my inability to do so due to associated medical condition.
I understand that I have to disclose my clinical history and other relevant information to the healthcare provider team required for the management of my disease. No changes will be permitted in medical records thereafter.
I am fully aware that the medical treatment may be extended beyond the expected period at the discretion of the doctor.
I/We undertake to pay any advance/deposit as and when required by the hospital and agree to settle bills before discharge of the patient.
The doctor's discretion shall be considered as final for my discharge, I assent for transfer out from your hospital to other hospital / nursing home in case of non-payment of bill/discretion of doctor.
I certify that I read the above and understand the contents. I further state I have been given an opportunity to ask question and all my question have been answered fully to my satisfaction.
I declare that my monthly Family income is Rs._____
I / We have been explained in detail the facilities available at **Dr L H Hiranandani Hospital.**
I / We have been explained in detail by my treating consultant about the proposed care, expected results and possible complications, risks, benefits and complications.
I / We have also been explained about the expected cost of the treatment by my treating consultant/hospital. I/We understand that the approximate cost of hospitalization in the chosen class would be ₹..... only for a maximum period of 2 days. However, this estimate is only an approximate figure and will vary depending on the clinical scenario and / or any other complexities arising during the course of stay and/or consumables that are required for the treatment of the patient in the hospital.

P.T.O

Note : * Mandatory Information

I / We undertake not to hold the Hospital responsible for any mishaps/accident that may occur at the Hospital during my stay.

We understand that the filling of this form does not automatically entitle the patient to admission, which is subject to the discretion of the Hospital. I/We further give consent to the release of professional and/or other information from the medical records as may be deemed necessary in accordance with policies, rules & regulations of the **Dr L H Hiranandani Hospital.**

If my financial credit status is disputed by credit/insurance company/TPA, I undertake to settle the final bill on the date of discharge, I also undertake to make payment against interim bills raised within stipulated time. I am aware that no changes in medical record will be permited.

I _____

hereby give consent to admit myself/my _____

Whose details have been mentioned herein the following Class.

Suite	Single Room (with day space)		Single Room	Twin Sharing (AC)
LDRP	ICU	ICCU	NICU	Multiple Sharing (AC)

I am / we are hereby making a payment of ₹. _____/- (Rupees_____

_____)

Patient

Name : _____

Signature : _____ Date : _____

Signature of consultant : _____

Name of consultant : _____

Next-ofkin/accompanying person (Mention relationship)
(To be filled in case patient is not in a condition to sign)

_____

_____

Instructions for the Charity Assistance

Those with annual income of more than Rs. 50,000 but less than Rs. 1,00,000 and wishing to avail financial assistance from the various Charitable Organizations will need to adopt the following procedure at the time of admission only.

- Approach MSW / Front Office with below listed documents
  1. Reference letter with case summary from the treating Physician
  2. Ration Card
  3. Photo ID
  4. Income Proof (Tahsildar Certificate)

Admission Information

Date	Time	Room No.	Procedure	Deposit