TOTAL WAIVER AND DISCLAIMER

I agree that I must accept personally all the risks associated with the current treatment of my medical and surgical conditions.

I agree that I will under no circumstances attempt financial compensation from my medical carers or their nursing or other assistants.

I understand that any third parties acting on my behalf will have no right on my behalf in claiming financial or other compensation for any outcome affecting me.

I understand that agreement to these principles is a condition for the commencement and continuance of my medical and surgical care. Therefore, if I do not wish to agree to these principles, I should not commence preparation for colonoscopy /gastroscopy and inform Southcoast Digestive Diseases Centre soonest possible.

I understand that I may arrange personal insurance to cover any accident or untoward events associated with my care, but agree that I will not allow the providers of that insurance any rights on my behalf to claim any compensation from my medical providers.

I understand that I may wish to seek legal advice before I sign this document.

I understand that Dr Chakravarty and all the associated medical and nursing staff who work with him will try to ensure the very best in medical outcome for me, but I understand that I cannot hold them financially at risk for their medical or surgical care.

PATIENT SIGNATURE: ……

NAME: ……..DATE:……..

WITNESS SIGNATURE: ..... DATE: .....

NAME: ……

FILE NO: ……..