Dr. Saurabh Kamat

Neurologist & Epilepsy Specialist

Consent Form

Patient Consent for Treatment

I, the undersigned, hereby give my consent to Dr. Saurabh Kamat, a certified neurologist, to perform diagnostic and treatment procedures related to my neurological condition. I understand that the treatment may include, but is not limited to, medical examination, imaging tests, procedures, and prescribed medications.

I acknowledge that Dr. Kamat has explained the nature, purpose, and potential risks of the proposed treatment and that I have had the opportunity to ask any questions about my condition and treatment options.

I understand that the results of the treatment or procedures may not be fully predictable, and I give my consent for necessary follow-up visits.

Patient Information:

- Name: _____
- Date of Birth: _____
- Contact Number: _____
- Email: _____

Patient's Signature: _____

Date: _____

Dr. Saurabh Kamat