

**Informed consent  
on the volume and conditions of paid medical services provided**

I, \_\_\_\_\_ year of birth,  
(for an incapacitated, partially capable person, the line is filled in by legal representatives: mother, father, adoptive parent, guardian, trustee)  
registered at: \_\_\_\_\_

who is the Patient, the legal representative under the contract for the provision of paid medical services No. \_\_\_\_ dated \_\_\_\_\_, wish to receive paid medical services at the Tambov Regional Dermatovenerologic Clinical Dispensary (hereinafter referred to as the Contractor), while it was explained to me and I realized the following:

1. Having received from the Contractor's employees full information about the possibilities and conditions for the provision of free medical services in the GBUZ TOKVKD, within the framework of the programs for receiving free medical care, I give my consent to the provision of paid medical services and am ready (a) to pay for them.
2. I express my voluntariness in receiving paid medical services, while I considered various options for obtaining medical services, and the fact that I can be provided with similar medical services in other medical institutions, on different conditions and on a free basis.
3. I express my voluntariness \* in receiving paid medical services and carrying out diagnostic procedures for me: obtaining samples of biological material for laboratory research, instrumental studies, doctor's examination, about the goals, nature and possible adverse effects of diagnostic procedures, as well as about what is in store for me to do before and during procedures on a paid basis.
4. I received (a) comprehensive information about the diagnosis, about the features of the course of the disease, about the duration of treatment, about the outcome of treatment, about the prognosis of the disease, about the circumstances that worsen the prognosis of the disease, about the proposed treatment plan and the rules of the therapeutic and protective regimen, and I undertake observe them.
5. I understand and understand that in order to obtain the best results of treatment, I must (a) follow all the prescriptions, recommendations and advice of the doctors (specialists) of the Contractor, immediately inform the doctor about any deterioration in well-being, agree with the doctor to take any non-prescribed medications and understand that the refusal of treatment, non-compliance with the medical and protective regime, the recommendations of medical workers, the regimen of taking medications, uncontrolled self-medication can complicate the treatment process and adversely affect the state of health.
6. The types of medical services I have chosen have been agreed with the attending physician (specialist), and I give my consent to carry out diagnostic and therapeutic measures for me: taking pills, injections, intravenous infusions and other procedures.
7. I have received information about other treatments that are comparable in terms of medical effectiveness and the possibility of obtaining medical care.
8. I have informed the doctor about all health problems, including allergic manifestations or individual intolerance to drugs, about all the injuries, operations, diseases that I have suffered and known to me, about the environmental and industrial factors of physical, of a chemical or biological nature, affecting me during my life, about the medications taken. I gave (a) true information about heredity, as well as about the use of alcohol, drugs and toxic substances.
9. I agree that the medical care technology used cannot completely exclude the likelihood of side effects and complications due to the biological characteristics of the body, and in the event that the service is provided in compliance with all the necessary requirements, the Contractor is not responsible for them occurrence.
10. It was explained to me that I can get both one of the types of paid medical services, and several types of services.
11. I have read (a) the current price list and agree to pay the cost of the medical services provided in accordance with it.
12. The types of paid medical services I have chosen have been agreed with the attending physician (specialist), and I agree to pay for them.
13. I certify that I have read the text of my informed consent to medical intervention, I understand the purpose of this document, the explanations received are clear and I am satisfied.
14. I have no objection to the recording of medical intervention on information carriers and demonstration to persons with medical education - exclusively for medical, scientific or educational purposes, taking into account the preservation of medical confidentiality.
15. I authorize, if necessary, to provide medical documentation and information about my state of health (my diagnosis, severity, nature of my disease, etc.) to the following persons: \_\_\_\_\_

\_\_\_\_\_ This informed consent was signed by me after a preliminary conversation about the provision of paid medical services.

Patient: \_\_\_\_\_  
Passport: series \_\_\_\_\_ No. \_\_\_\_\_ issued by \_\_\_\_\_

The address: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(patient signature) / (patient name)

" \_\_\_\_\_ " \_\_\_\_\_ year.