Surgical Clinics of Dr. Antal Kálló

Szentendre 2000 Rab Rábi tér 3.
Hours: Wednesday 17:00 – 20:00 hrs.
Even Saturdays 11:00 – 17:00 hrs.
Tel: 26 317 936 Mobil: 06 30 2036702

Budapest 1016 Krisztina krt. 87/89
Hours: Tuesday, Thursday 16:00 – 19:00 hrs.
E-mail: a.kalo@chello.hu
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Consent Form
for surgery

Undersigned....., I received detailed information regarding the following:

- **My present medical condition**
- **Suggested treatment or surgery**
- **Expected outcome of the treatment**
- **Consequences if treatment is not given**
- **Side effects and other unpleasant experiences that may be caused by the treatment**
- **If the medications, materials and the procedure have been approved by the Hungarian health authorities, if available through the regional, state financed health care, if National Health Services cover the treatment costs**
- **Expected cost of the treatment /exemption from V.A.T./**

I have understood the above information, and received satisfactory answers to my questions. On the basis of this information I decided to request the suggested treatment with the agreed upon conditions and cost. I commit to cooperate to my best capabilities and keep myself to the given instructions to ensure the success of the treatment. I accept that medical services are not success-bound. Possible recurrence or related problems can follow even the most careful and thorough treatment. In such a case or in any other unforeseen complication that results from my condition, I shall not present demands.
I received complete and acceptable information regarding the cost of the treatment.
I received / did not receive written information.

My condition:.....

Suggested treatment:.....

.....day.....month.....2003.

..... **.....**
Dr. Kálló Antal **Patient or legal guardian**