Vascular & Endovascular Associates
Comprehensive Vascular Center

PAUL G. BOVE, M.D., F.A.C.S., F.S.V.M.
GRAHAM W. LONG, M.D., F.A.C.S.
MACIEJ R. UZIEBLO, M.D.
SCOTT M. SILVER, M.D.

525 East Big Beaver Road • Suite 125 • Troy, MI 48083 • Phone: 248.688.9860 • Fax: 248.688.9861 • www.michiganvascularsurgeons.com

GENERAL CONSENT TO TREAT

DATE: _____

PATIENTS NAME: _____

DATE OF BIRTH: _____ MRN: _____

- **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her assistants participating in my care. This care may include; diagnostic, laboratory or radiology procedures; anesthesia, therapeutic procedures, nursing, hospital or blood transfusions. I understand I will sign an informed consent IF surgery or surgical procedure is recommended.
- **Release of Information:** I authorize Vascular & Endovascular Associates, PLC to release pertinent information and/or copies of medical records for treatment, payment or health care operation purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDES Related Complex (ARC) and Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records and social work records, if any. See notice of Privacy Practices for further information.
- **Payment:** I assign and authorize payment from my insurance company directly to Vascular & Endovascular Associates, PLC Professional Services for any and all services rendered. I agree to pay, at the time of completed services all charges not covered by my insurance company. I understand that it is my primary responsibility to pay all charges for services rendered irrespective of any disputes or disagreements between myself and the insurance company.
- **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I knowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized. I release Vascular & Endovascular Associates, PLC all responsibility for personal articles which I have with me during the time I am a patient. I understand the office is not responsible for personal articles of value kept in my possession while a patient at the office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I reviewed a copy of the Notice of Privacy Practices.

_____

Patient or Representative Signature Date

Acknowledgement of receipt of Notice of Privacy Practice was not obtained because: _____

_____

_____

I have read this form, or it has been read to me and I am satisfied that I understand its contents. I further understand that this content will be deemed continuing and I am free to withdraw my consent at any time.

Signature of Patient: _____ Date: _____

VEA
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Beginning June 1, 2018:

Due to new government regulations, all narcotic prescriptions require practitioners to check and update the Michigan Automated Prescription System (MAPS) prior to prescribing a narcotic medication. Some of the changes to the prescription of narcotic medications include the following:

- Requests may be made only during regular office hours (8:00 AM to 4:00 PM), Monday through Friday or during regularly scheduled office visits.
- Refill requests will not be honored on nights, weekends and holidays.
- **Narcotic prescriptions cannot be written for more than a 7-day supply**.
- Requests will not be honored if patients run out early, lose a prescription or spill/misplace medications.
- Only written prescriptions will be given and no narcotic prescriptions will be telephoned or fazed to the pharmacy.
- **Refill requests for narcotic medications require at least 3 business days (72 hours) notice**, to allow enough time for the provider to check and update the Michigan Automated Prescription System (MAPS).
- To help both providers and patients to comply with the law regarding narcotics, patients will be required to sign an “Informed Consent” acknowledging that”
    - They have received information regarding the danger of opioid addiction.
    - How to properly dispose of unused controlled substances.
    - Delivery of a controlled substance is a felony under MI law.
    - Short-and-long term effects of exposing a fetus to a controlled substance.

PLEASE PLAN AHEAD! We cannot accommodate same day requests for pain medication.

All Other Prescription Refills”

- We require at least a 72 hour (3 business days) notice for refill and prescription requests. Please plan accordingly.
- We also encourage you to contact your pharmacy before going to pick up your prescription to make sure it is ready.

**I have read and understand the guidelines of the Vascular and Endovascular Associates.*

Signature: _____ Date: _____

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Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment or Ultrasound

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 30 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 3 days in advance you will be charged a one hundred dollar ($100) fee; this is will not be covered by your insurance company.

4. Account Balances

Patients who have questions about their bills or who would like to discuss a payment plan option may call and speak to a billing representative who can review their account and concerns.

_____ Date _____

Signature (Patient or Guardian)

_____

Print Name (Patient or Guardian)

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ADVANCED DIRECTIVE / LIVING WILL **DATE:_____**

Do you have an Advanced Directive or Living Will? (Circle one)

YES NO

Signature of Patient: _____ Date: _____

If YES – please bring a copy of it with you to your next appointment so we may add it into your Beaumont Health System record.

Thank you

Note: A directive allows you to plan your medical treatment in advance should there ever come a time when you are unable to express your personal health care wishes.

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Patient Medical History Form

Name _____ Today's Date _____

DOB _____ Age _____ Sex _____ Allergies: _____

Reason for Visit _____ Primary Care Physician _____

Smoker: ☐No ☐Yes How many years?_____ PPD _____ Year Quit: _____ Ready to Quit? ☐Yes ☐No

How much alcohol do you drink? _____ Recreational Drug Use? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No Do you require assistance at home? ☐ Yes ☐ No

Past Medical History

Aneurysm	Y	N
Bleeding Disorders	Y	N
Blood Clots	Y	N
Cancer	Y	N
Carotid Disease	Y	N
Diabetes	Y	N
Deep Vein Thrombosis	Y	N
Heart Disease	Y	N
Hypertension	Y	N
Lipid/Cholesterol	Y	N
Renal Insufficiency	Y	N
Stroke	Y	N
TIA	Y	N
Varicose Veins	Y	N

Other: _____

Family History

Abdominal Aortic Aneurysm	Y	N	Who _____
Bleeding Disorders	Y	N	Who _____
Blood Clots	Y	N	Who _____
Cancer	Y	N	Who _____
Diabetes	Y	N	Who _____
Heart Disease	Y	N	Who _____
High Cholesterol	Y	N	Who _____
Hypertension	Y	N	Who _____
Stroke	Y	N	Who _____
Sudden Death	Y	N	Who _____
Varicose Veins	Y	N	Who _____

Other: _____

_____

_____

Past Surgical History

Abdominal Aneurysm Repair	Y	N When_____
Carotid Artery Surgery	Y	N Left/Right/Both When: _____
Open Heart Surgery	Y	N
Coronary Stent/Angioplasty	Y	N
Leg Vein Surgery	Y	N When_____
Leg Artery Surgery	Y	N When _____
Dialysis Access Graft	Y	N When_____

Other: _____

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PATIENT INFORMATION				
Last Name:	**First:**	**Middle:**	**Patient ID#:**	**Birth Date:**
Street Address:			**Home Phone:**	
P.O. Box:	**City:**		**State:** MI	**ZIP Code:**
Pharmacy Name:			**Pharmacy Phone:**	

IN CASE OF EMERGENCY	
Contact Name:	**Contact Phone:**
Next of Kin Name:	**Next of Kin Phone:**

CURRENT MEDICATION – PRESCRIPTION & OVER-THE-COUNTER		
Name of Current Medication(s):	**Dose of Medication**	**How Often Do You Take This Medication?**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		

ALLERGIES – FOOD, MEDICATION & ENVIORNMENTAL	
Allergic To:	Describe Reaction: