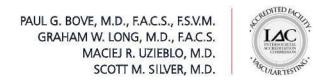


GENERAL CONSENT TO TREAT	DATE:
PATIENTS NAME:	
DATE OF BIRTH:	MRN:
physician and his/her assistants particip	I or surgical treatment as may be deemed necessary and appropriate by the pating in my care. This care may include; diagnostic, laboratory or radiologocedures, nursing, hospital or blood transfusions. I understand I will sign approcedure is recommended.
Release of Information: I authorize Vascu	ular & Endovascular Associates, PLC to release pertinent information and/o
may include Human Immunodeficiency	e, payment or health care operation purposes. I understand such information Virus (HIV), AIDES Related Complex (ARC) and Acquired Immunodeficience abuse, psychiatric/psychological services records and social work records, auther information.
Associates, PLC Professional Services for services all charges not covered by my	ment from my insurance company directly to Vascular & Endovascular or any and all services rendered. I agree to pay, at the time of complete insurance company. I understand that it is my primary responsibility to paective of any disputes or disagreements between myself and the insurance
\square No Guarantees: I am aware that the pra	ctice of medicine and surgery is not an exact science and I knowledge tha
authorized. I release Vascular & Endov	made to me as to the results of the care and treatment which I have hereby ascular Associates, PLC all responsibility for personal articles which I havent. I understand the office is not responsible for personal articles of valuate the office.
ACKNOWLEDGEMENT OF	RECEIPT OF NOTICE OF PRIVACY PRACTICES
I reviewed a copy of the Notice of Privace	y Practices.
Patient or Representative Signature	Date
Acknowledgement of receipt of Notice of	of Privacy Practice was not obtained because:
	ad to me and I am satisfied that I understand its contents. I further emed continuing and I am free to withdraw my consent at any time.
Signature of Patient:	Date:





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)
 <u>notice</u>, 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.

1 have read and understand the	guidelines of the Vascular and Endovascular Associates.	
Signature:	Date:	



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.

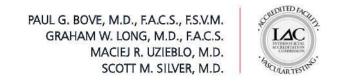
If surgery is not cancelled at least 3 days in advance you will be charged a one hundred dollar (\$100) fee; this is will not be covered by your insurance company.

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)	





DATE:							
or Living Will? (Circle one)							
,							
NO							
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.							

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.





Patient Medical History Form

Name			Today's Date					
DOB		Age	e Sex	Allergie	s:			
Reason for Visit		Primary Care Physician						
Smoker: No Yes How many years? PPD Year Quit: Ready to Qu						to Quit? □	lYes □No	
How much alcohol do you drink?				Recreational Drug Use? Yes				
Do you live alone? \Box	Yes 🗆	□ No	Do you	require assist	ance	at home?	☐ Yes	□ No
Past Medical History			Family History					
Aneurysm	Υ	N	Abdominal Aortic	Aneurysm Y	Ν	Who		
Bleeding Disorders		N	Bleeding Disorder	•	Ν	Who		
Blood Clots	Υ	N	Blood Clots	Υ	Ν			
Cancer	Υ	N	Cancer	Υ	Ν	Who		
Carotid Disease	Υ	N	Diabetes	Υ	Ν	Who		
Diabetes	Υ	N	Heart Disease	Υ	Ν	Who		
Deep Vein Thrombosis	Υ	N	High Cholesterol	Υ	Ν	Who		
Heart Disease	Υ	N	Hypertension	Υ	Ν	Who		
Hypertension	Υ	N	Stroke	Υ	Ν			
Lipid/Cholesterol	Υ	N	Sudden Death	Υ	Ν	Who		
Renal Insufficiency	Υ	N	Varicose Veins	Υ	Ν	Who		
Stroke	Υ	N	Other:					
TIA	Υ	N						
Varicose Veins	Υ	N						
Other:								
Past Surgical History	nair	V	N When					
Abdominal Aneurysm Repair Y			N Left/Right/Both When:					
Carotid Artery Surgery		Y		Both when:				
Open Heart Surgery		-	Y N					
Coronary Stent/Angiopla	sty		Y N					
Leg Vein Surgery		Y	N When					
Leg Artery Surgery		Υ	N When					
Dialysis Access Graft		Y	N When					
Other:								



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☐ Paul G. Bove, M.	.D. 🗌 Graham W	. Long, M.D	. \square Maciej	R. Uzieblo, M.D.	☐ Scott M. Silver, M.D.		
		PATIENT	INFORMATIO	N			
Last Name:	First:		Middle:	Patient ID#: Birth Date:			
Street Address:	Γ			Home Phone:			
P.O. Box:	City:			State: MI	ZIP Code:		
Pharmacy Name:				Pharmacy Phone:			
IN CASE OF EMERGENCY							
Contact Name:							
Next of Kin Name:			Next of Kin Pho	one:			
	CURRENT MEDICA	ATION — PR	ESCRIPTION &	OVER-THE-COU	NTER		
Name of Current Medic	ation(s):	Dose of Med	lication	How Often Do Y	ou Take This Medication?		
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
ALLERGIES - FOOD, MEDICATION & ENVIORNMENTAL							
Allergic To:			Describe R	Reaction:			