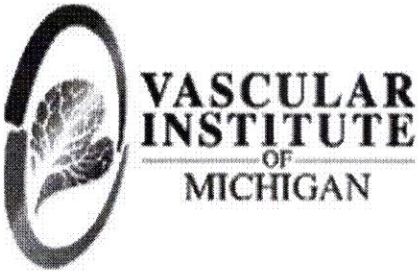

Dr. Babatunde Almaroof
Dr. Mohmmed Margni
Karen Wiltse, ANP-BC

1325 S Linden Rd
Flint, MI 48532
PH: 810-535-5555
Fax: 810-275-1556

CANCELLATION AND NO SHOW POLICY

At Vascular Institute of Michigan, we do our best to schedule our appointments so that each patient is given the appropriate amount of time to receive the best care by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

To help patients remember their scheduled appointments, Vascular Institute of Michigan makes reminder calls 1 week and then 1 day in advance of the scheduled appointment date.

If your schedule changes and you are unable to keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office, as well as to those patients who are waiting, if you need to cancel or reschedule your appointment, please provide at least 24 hours notice if possible. Please refer to the table below for our cancellation and rescheduling policy. This policy applies to consecutive (in a row) cancellations:

SCHEDULED SERVICE	Number of Consecutive Cancellations/No shows allowed
Consultation/follow up visit	3
Ultrasound Testing	3
Procedures	2

If you exceed the number of cancellations indicated in the above table, you will not be allowed to reschedule your appointment.

By signing below, I understand the "Cancellation and No-Show" policy of Vascular Institute of Michigan.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

VIM Staff Signature: _____

VASCULAR INSTITUTE OF MICHIGAN

1325 S. Linden Rd
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Mohmmed Margni, MD
Babatunde Almaroof, MD
Karen Wiltse, NP

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Vascular Institute of Michigan as your healthcare provider. We are committed to providing you with the highest quality of healthcare. We ask that you read, initial and sign this form to acknowledge your understanding of our patient financial policies.

We will bill your insurance on your behalf. We make every effort to verify coverage, benefits and out of pocket expenses prior to your visit; however, it is ultimately your responsibility to know any out of pocket expenses that may be associated with your health plan, such as deductibles, co-pays, coinsurances, out-of-network costs or non-covered services.

INDIVIDUALS FINANCIAL RESPONSIBILITY (Initial each line below)

_____ I understand that Vascular Institute of Michigan participates with most insurance plans, which means they accept my health plan's allowed amount for health care services as full payment. In the event they do not participate with my health plan, I will be responsible for any out-of-network charges incurred.

_____ I understand that I am financially responsible for my health insurance deductible, coinsurance or co-pays

_____ I am responsible for providing the correct and most up to date insurance information

_____ I understand that co-payments are due at the time of service

_____ If my health plan requires a specialist referral, I must be sure it is obtained prior to my visit

_____ If I am uninsured, I agree to pay for any medical services rendered to me at the time of service.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

_____ I hereby authorize and direct payment of my medical benefits to Vascular Institute of Michigan on my behalf for any services rendered to me by the providers.

****Please only initial here if you have Medicare****

_____ **MEDICARE REQUEST FOR PAYMENT** I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by or in Vascular Institute of Michigan. I authorize any holder of medical or other information about me to be released to Medicare and its agents for any information needed to determine these benefits for related services.

By my signature below, I indicate that I have read, understand and agree to the provisions of the Patient Financial Responsibility Form.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party **Date**

_____ _____

Print Name of Patient, Authorized Representative **Relationship to patient**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell? **YES** **NO**

May we discuss your medical condition with any member of your family or friends? **YES** **NO**

(If yes please list names below)

_____

This consent was signed by: _____

(Print Name)

Signature: _____ Date: _____

Witness: _____ Date: _____

VASCULAR INSTITUTE OF MICHIGAN

Vascular Institute of Michigan

1325 S. Linden Rd. Flint, MI 48532

Phone: 810-535-5555

Fax: 810-275-1556

☆ PLEASE COMPLETE AND BRING WITH YOU TO YOUR APPOINTMENT ☆

NOTE: This is a confidential record and will be kept in our office. This information will not be released to anyone without your authorization.

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

STREET ADDRESS: _____ SOC. SECURITY #: ____-____-____

CITY/STATE/ZIP: _____ GENDER: ☐ MALE ☐ FEMALE

PREFERRED PHONE: _____ ☐ HOME ☐ MOBILE ☐ WORK

SECONDARY PHONE: _____ ☐ HOME ☐ MOBILE ☐ WORK

EMERGENCY CONTACT NAME: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

CARDIOLOGIST: _____ PODIATRIST: _____ DIALYSIS CENTER: _____

PRIMARY INSURANCE PLAN: _____ POLICY # _____

☆ COMPLETE THIS BOX IF YOU ARE NOT THE POLICY HOLDER:

INSURANCE POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____

POLICY HOLDER NAME: _____ D.O.B: ____/____/____

SECONDARY INSURANCE PLAN: _____ POLICY # _____

VASCULAR INSTITUTE OF MICHIGAN

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

MEDICATION	DOSAGE	FREQUENCY

Please list any **ALLERGIES** to medication or food:

ALLERGIES	REACTION

REFERRED PHARMACY: _____ **PHONE:** _____

VASCULAR INSTITUTE OF MICHIGAN

History of Past and Present Medical Conditions

Do you have any of these medical conditions currently or in the past? Please select "Yes" or "No"

Migraine Headaches	☐ YES	☐ NO
Epilepsy or Convulsions	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Chronic Bronchitis	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO
Congestive Heart Failure	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Vomiting Blood	☐ YES	☐ NO
Rectal Bleeding	☐ YES	☐ NO
Kidney Problems	☐ YES	☐ NO
Phlebitis	☐ YES	☐ NO
Blood Clots in Arteries	☐ YES	☐ NO
Deep Vein Thrombosis	☐ YES	☐ NO
Pulmonary Embolism	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
High Cholesterol	☐ YES	☐ NO
Thyroid-Overactive	☐ YES	☐ NO
Thyroid-Underactive	☐ YES	☐ NO

Operations

Tonsils	☐ YES	☐ NO	Date: _____
Appendix	☐ YES	☐ NO	Date: _____
Gall Bladder	☐ YES	☐ NO	Date: _____
Stomach	☐ YES	☐ NO	Date: _____
Kidney	☐ YES	☐ NO	Date: _____
Colon	☐ YES	☐ NO	Date: _____
Thyroid	☐ YES	☐ NO	Date: _____
Hernia	☐ YES	☐ NO	Date: _____
Varicose Veins	☐ YES	☐ NO	Date: _____
Heart Bypass	☐ YES	☐ NO	Date: _____
Heart Angioplasty	☐ YES	☐ NO	Date: _____
Heart Stent	☐ YES	☐ NO	Date: _____
Back	☐ YES	☐ NO	Date: _____
Arteries	☐ YES	☐ NO	Date: _____
Breast	☐ YES	☐ NO	Date: _____
Uterus	☐ YES	☐ NO	Date: _____
Prostate	☐ YES	☐ NO	Date: _____
Kidney Transplant	☐ YES	☐ NO	Date: _____
Dialysis Graft	☐ YES	☐ NO	Date: _____
Dialysis Catheter	☐ YES	☐ NO	Date: _____

VASCULAR INSTITUTE OF MICHIGAN

Social History

Alcohol Use: ☐ Daily Limited Use ☐ History of Alcoholism ☐ Current Alcoholism
☐ Never Drinks Alcohol ☐ Drinks Alcohol

Tobacco Use: ☐ Current Tobacco User, Packs Per Day_____ How many years smoker _____
☐ Former Tobacco User ☐ Has Never Used Tobacco

Illegal Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Uses Marijuana
☐ Formerly Used Illegal Drugs (Which : _____)
☐ Currently Use Illegal Drugs (Which : _____)

Family History

Has any immediate family ever had any of the following? Please Select "Yes" or "No"

Abdominal Aortic Aneurysm	☐ Yes	☐ No	Who_____
Blood Clots	☐ Yes	☐ No	Who_____
Cancer	☐ Yes	☐ No	Who_____
Diabetes	☐ Yes	☐ No	Who_____
Heart Trouble	☐ Yes	☐ No	Who_____
High Blood Pressure	☐ Yes	☐ No	Who_____
Stroke	☐ Yes	☐ No	Who_____
Bleeding Disorder	☐ Yes	☐ No	Who_____
Varicose Veins	☐ Yes	☐ No	Who_____
Vascular Disease	☐ Yes	☐ No	Who_____

Other _____ Who_____

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System Review

Please select all that apply

General

- ☐ Fatigue
- ☐ Change in appetite
- ☐ Fever/Chills
- ☐ Headaches
- ☐ Weight loss

Cancer: Type_____

Respiratory

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Lobectomy

Gastrointestinal

- ☐ Constipation
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Nausea

Peripheral Vascular

- ☐ Poor Circulation
- ☐ Peripheral Arterial Disease
- ☐ Un-healing Wounds
- ☐ Pain with Walking
- ☐ Bulging Varicose Veins
- ☐ Swelling
- ☐ Redness
- ☐ Coolness in Extremities
- ☐ Burning in Extremities
- ☐ Numbness/Tingling
- ☐ Pain in Extremities
- ☐ Raynaud's Syndrome
- ☐ Lymph Node Enlargement

HEENT

- ☐ Dizziness
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Eye Pain
- ☐ Floaters in Vision
- ☐ Difficulty Swallowing
- ☐ Dentures
- ☐ Neck Stiffness

Cardiovascular

- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Palpitations
- ☐ Coronary Artery Disease
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ CABG
- ☐ Pacemaker

Musculoskeletal

- ☐ Back Pain
- ☐ Joint Swelling/Stiffness
- ☐ Joint Pain
- ☐ Difficulty Walking
- ☐ Weakness
- ☐ Neck Pain
- ☐ Muscle Cramps

Arthritis: Type_____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ OCD

System Review Cont.

Please select all that apply

Neurological

- Dementia ☐
- Alzheimer's disease ☐
- Dizziness/Vertigo ☐
- Parkinson's disease ☐
- Insomnia ☐
- Poor Balance ☐
- CVA (STROKE) ☐
- TIA (MINI STROKE) ☐
- Seizures ☐
- Restless Leg Syndrome ☐
- Peripheral Neuropathy ☐
- Brain Injury ☐

SKIN

- Rash ☐
- Psoriasis ☐
- Dryness ☐
- Changes in Skin Color ☐
- Skin Ulcerations ☐

ENDOCRINE

- Sensitive to cold or heat ☐
- Taking Thyroid Medication ☐
- Over Active Thyroid ☐
- Under Active Thyroid ☐
- Goiter ☐
- Diabetes ☐

Hematology/Oncology

- Anemia ☐
- Bleeding Disorder ☐
- Blood Clots (DVT) ☐
- Thrombophlebitis ☐
- Easy Bruising ☐
- Hepatitis ☐
- HIV ☐
- HTT (Heparin induced thrombocytopenia) ☐

GENITOURINARY

- Painful Urination ☐
- Urinary Incontinence ☐
- Hematuria ☐
- Difficult Urination ☐
- Cloudy Urine ☐
- Frequent Urination ☐
- Bladder Infections ☐
- Kidney Disease ☐
- Dialysis ☐
- Frequent UTI's ☐

Patient/Legal Guardian Signature: _____ Date: ____/____/____

Staff Signature: _____ Date: ____/____/____

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