Vascular Health Center
Comprehensive Vascular Care

Tarek El-Shaarawy, M.D.
Syed M. Faisal Alam, M.D.

AUTHORIZATION FOR TREATMENT FORM

Medical care is a patient care/service provided in response to a wide range of medical care/service needs of patients of all ages regardless of gender, color, race, creed, national origin, or disability five (5) days a week.

The purpose of medical care is to treat disease, injury, and disability by examination, testing and use of procedures in the aid of diagnosis or treatment; to obtain information needed in diagnosing and examination of patients; to prevent or minimize residual physical and mental disability; to aid patients in achieving their maximum potential within their capabilities; and to accelerate convalescence and reduce the length of the functional recovery.

You are not expected to experience any increase in your current level of pain or discomfort. You are expected to cooperate fully with the examination and stop any test or treatment before any increase in your current level of pain or discomfort. Because of the nature of services provided, you may be asked to disrobe or partially disrobe. If this is necessary, your privacy, modesty and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request the presence of another person of the same gender.

There are certain inherent risks with medical treatment. There is also a possibility that you could experience a new injury, but this risk is small, and you will be able to control any procedure by stopping if you feel any increase in pain or discomfort. You will also be able to stop treatment if you feel any discomfort in any other part of your body. The treating medical practitioner will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. The clinic reserves the right to restrict visitors and outside communication at any time during your medical treatment sessions to ensure you receive the maximum therapeutic value from treatment. The law requires all staff members to report any evidence of abuse, neglect and/or exploitation of patients. Should you observe any abuse, neglect, or exploitation by an individual in the clinic, you are encouraged to report it immediately. Should you wish to file a complaint or grievance for any reason, you will be provided, in written form, with the names and addresses of appropriate individuals and protective agencies and, if necessary, be given appropriate privacy to complete your communication with those individuals/agencies.

3790 Capital Avenue S.W. • Battle Creek, MI 49015
Phone (269) 979-6310 • Fax (269) 979-8807

Based on the above information, I agree to cooperate fully, to participate in all medical procedures and to comply with the plan of care/services as it is established. I acknowledge that I have read and received copies of the Authorization for Treatment and Patient's Rights and Responsibilities and authorize release of medical information to the appropriate third parties.

NOTICE: For your personal safety, do not use or tamper with any equipment.

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PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

_____ _____

WITNESS SIGNATURE **DATE**