

**COMPREHENSIVE VASCULAR CARE, P.C.**  
**22250 Providence Drive, Suite 555**  
**Southfield, MI 48075**  
248-424-5748

**CONSENT FOR PROCEDURE**

Name of Patient: \_\_\_\_\_

1. I hereby request and authorize Doctor \_\_\_\_\_ and/or such assistants as may be selected by him/her, and aided by such associates, assistants and practice personnel as may directed by him/her to perform the procedure listed below (also see procedure site identification diagram on back):

\_\_\_\_\_ (If applicable:

Right  Left

2. I fully understand that in preparation for, during and following the contemplated procedure, conditions may be revealed or discovered that in the judgment of the physician and others referred to above, make necessary or advisable a different procedure or extension of the originally contemplated procedure. I, therefore, request and authorize the physician and others referral to above to perform these additional procedures.
3. I hereby authorize COMPREHENSIVE VASCULAR CARE, P.C. a Michigan Corporation, to undertake its appropriate services and care necessary, attendant to and in conjunction with those procedure undertaken to alleviate my condition or conditions.
4. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that risks, consequences and complications may be associate with the procedure to be undertaken and that no guarantees have been made to me concerning the results of these.
5. I consent to the administration of such medications and anesthetics as may be considered necessary or advisable by the physician responsible for this service with the exception of those to which I am allergic or to which I object as follows. \_\_\_\_\_
6. I consent to the observation; photography or videotaping of the procedure to be performed for medical, scientific or education purpose provided my identity is not revealed by the pictures or by the descriptive texts accompanying them.
7. I hereby authorize COMPREHENSIVE VASCULAR CARE, P.C. to retain, photograph, preserve and use for scientific or teaching purposes or dispose of, at their convenience, any part, specimen or tissue taken from my body.
8. I have had the opportunity to ask questions about the procedure listed above and about the risks and benefits of the proposed procedure, as well as alternative forms of treatment. My questions have been answered to my satisfaction. I may withdraw my consent at any time.

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

