THE NEW JERSEY
VEIN AND VASCULAR CENTER
390 Route 10 West, North Building Suite 102
Randolph, NJ 07869
Stuart H. Miller, M.D.

INFORMED CONSENT TO PERFORM HEALTH SCREENING

This Informed Consent gives the New Jersey Vein and Vascular Center (the "**Center**") permission to conduct the health screening listed below. Please read this Informed Consent carefully.

I voluntarily and willingly consent to have the **Center** administer and conduct the following health screening: **varicose veins of the legs**. I understand I may be touched on my leg(s) and consent to such touching. I understand that there are possible risks associated this health screening, including, without limitation: (1) pain from touching my legs, and (2) a worsening of my varicose vein condition, and (3) other injury such as pulmonary embolism or death.

I understand that:

☐ I am entitled to receive a copy of this Informed Consent, my health screening results, and any other protected health information that is collected by the **Center** in connection with my health screening.

☐ A diagnosis can only be made by a qualified physician or licensed healthcare professional;

☐ The health screening results collected hereby the **Center** will be held securely and confidentially by the **Center.**

☐ The health screening results will not be shared with anybody, unless I sign additional documents.

☐ I understand that I will not receive any compensation and that the value of this health screening is nominal. I understand there is no fee for providing this health screening. I believe this health screening complies with all laws, regulations and rules relating to this health screening.

☐ I will not be permitted to participate in any other health screening offered by the **Center** for the twelve (12) month period following this health screening.

☐ I understand I am not obligated to use the service of the Center and should it be determined that follow up medical care is suggested I am free to select the health care provider of my choice, which may be the Center or any other health care provider.

☐ The health screening results will not be used by the **Center** unless I voluntarily choose to do so.

☐ I am responsible for contacting my primary care doctor for questions about any specific medical needs that may be indicated by this health screening. I will not hold the **Center** responsible for providing information, diagnosis or treatment as a substitute for the care I receive from my physician or any other qualified health care provider.

☐ If I have an abnormal health screening result, I am responsible for following-up with my primary care physician.

☐ I may revoke this Informed Consent by sending a written revocation to: **New Jersey Vein and Vascular Center**, **390 Route 10 West North Building Suite 102, Randolph, New Jersey 07869**. Revocation of this Informed Consent will not affect actions the **Center** takes in reliance on this Consent before the **Center** receives your written revocation.

I recognize that if I do not sign this Informed Consent, the **Center** cannot administer the health screening.

I have had full opportunity to read and considered the contents of this form.

_____ _____

Printed Name Date of Birth (mm/dd/yy)

_____ _____

Signature Date