Vascular Institute *for* Erectile Dysfunction

PATIENT NAME:_____ DOB:_____TODAY'S DATE: _____

Consent for Medical Services & Treatment

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by the physicians and ancillary providers of Vascular Institute for Erectile Dysfunction. I understand that the treatment, services & procedures offered by Vascular Institute for Erectile Dysfunction are novel and are not considered standard of care by the American Urology Association.

Patient Signature: _____Date: _____

Consent for Penile Examination

I specifically consent to a Penile Examination by Providers at Vascular Institute for Erectile Dysfunction when medically necessary and appropriate. A Penile Examination is a series of tasks that comprise an examination of the Penis using any combination of modalities, which may include, but need not be limited to, a provider's gloved hands, instrumentation, ultrasound or CT scan. As it relates to a Penile Examination , I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended by my Provider.

Patient Signature: _____Date: _____