

CONSENT FOR PROCEDURE: Vein Ablation

Procedure Date: _____

INFORMED CONSENT:

I understand the nature of my condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches as has been explained to me. I understand that there is a chance that major risks or complications of the procedure may occur, including (if applicable) but not limited to infection, hemorrhage, nerve injury, drug reactions, blood clots, loss of sensation, and loss of limb function.

I also understand that with any procedure, there is always the possibility of an unexpected complication, and no guarantees or promises have been made to me concerning the results of any procedure or treatment. I understand that during the procedure, unexpected findings or circumstances may require changes or additions to the planned procedure, and I authorize my physician to make decisions (including those not listed within) in my best interest. I have been provided with information about preventing surgical infections and was given an opportunity to ask questions.

Specific additional risks for this procedure, if applicable, may include, but are not limited to:

- Bleeding
- Bruising
- Infection
- DVT/PE
- Sensory or motor nerve damage
- Inflammation and hyperpigmentation
- Unsatisfactory Results

[Physician Name] will perform the procedure. The procedure may also involve the participation of medical assistants, nurse practitioners, and/or physician assistants. My physician will determine when it is necessary for others to participate in my care. I understand that it is possible that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) may be present during this procedure for advisory purposes only. Since aspects of this procedure may have educational value, data, video or photographs may be obtained for teaching purposes, presentations at medical/scientific meetings or publications in medical scientific journals. All such recordings used for teaching purposes will be de-identified.

PROCEDURAL SEDATION IS PLANNED TO BE USED AND/OR MAY POTENTIALLY BE USED FOR THIS PROCEDURE.

My physician has discussed the use of Procedural Sedation. The risks include but are not limited to slower breathing and low blood pressure that may require treatment, and occasionally

incomplete pain relief. I understand that procedural sedation involves risks including allergic reactions, aspiration, cardiac events, or other unforeseen complications. Additional comments (if any): Efficacy - Because all individuals are different, it is not possible to completely predict who will benefit from the procedure. Some patients will have very noticeable improvement, while others may have little or no improvement. A series of treatments may be needed for maximum results.

Vein Treatment Expectations: Our goal is to treat the medical symptoms of your vein disease which may include muscle cramping, achiness, heaviness, burning, and itching. While your medical insurance does not cover any cosmetic procedures, some patients may see significant improvement in the appearance of varicose veins and swelling. However, the treatment of cosmetic spider veins will require additional treatment that is not covered by insurance.

The above risks and benefits have been explained to me. Additionally, I understand that my adherence to post-procedure instructions, including wearing compression stockings and attending follow-up appointments, is essential for optimal results and minimizing complications. I have had an opportunity to fully inquire about the risks and benefits of this procedure and its alternatives. All my questions were answered to my satisfaction and I consent to the procedure.

PATIENT:

PATIENT SIGNATURE: _____

DATE:

WITNESS:

WITNESS SIGNATURE: _____

DATE: