Aesthetic
SOLUTIONS NY

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Sclerotherapy Consent Form

Name: _____ Date of Birth _____

I understand that medicine is not an exact science, and that though the vast majority of patients are satisfied with their results, there is no guarantee that I myself will be satisfied with the improvement of my veins after treatment. I acknowledge that the following topics have been fully explained to me, and that I understand the explanations I was given. I have had the opportunity to ask questions. I will be undergoing a vein removal procedure that involves the use of sclerotherapy. This consent form is provided as a means of education between the provider and the patient as to the methods and risks involved in vein removal. I understand that sclerotherapy treatments may be repeated several times.

Methods/Options:

1. Prior to any procedure the physician will consult the patient.
2. The consultation time will allow for assessment of the problem, determination of a diagnosis, development of a treatment plan, and discussion of what my options are if I choose to do nothing about my vein problem.
3. Diagnostic evaluations utilizing Doppler and or ultrasound may be required.
4. Treatment may include Sclerotherapy, using physician-determined appropriate energy levels and dosages.
5. The sclerosing agent, Polidocanol, may be used in my procedure. Polidocanol is not yet approved by the FDA, but it is widely used by many vein specialists in the United States and is considered by many specialists to be the safest sclerosing agent with the fewest of side effects.
6. Photographs of the treatment area may be taken for the chart and for future comparison.

Risks:

1. Pain, burning, blister formation, and stinging sensation at the treatment site.
2. Infection associated with the treatment site.
3. Pigment (color) changes at the treatment site, including hyperpigmentation (increase in skin color or darkening).
4. Scar formation at the treatment site.
5. Poor cosmetic outcome.
6. Reoccurrence of vessels at the treated site.
7. Allergic reaction, possibly severe or life-threatening.
8. Superficial or deep clot formation (deep vein thrombosis).
9. Bleeding and/or bruising at the treatment site.
10. Ulcer formation at the treatment site.
11. Temporary phlebitis (vein inflammation) at the treatment site.
12. Matting (bruised appearance that is often temporary, but sometimes permanent).

BENEFITS:

1. Lightening of the veins at the treatment site.
2. Complete removal of the veins in the treatment area.

I recognize that even though any particular problem may be extremely rare, it is always possible that any patient may have one of these problems. I accept that responsibility for my own treatment. I understand that I am responsible for my own medical bills. I realize that most insurance companies do not cover treatment of spider veins and that I must pay for my treatment today. I authorize this practice to submit my bill to my insurance company and to receive reimbursement. If my insurance company reimburses this practice for the services in which I am paying for today I will receive a refund of payment from this practice.

_____ _____

Patient Signature Date

I have discussed the above with the patient and have answered their questions.

_____ _____

Provider signature Date

*Be Advised: All Packages Must Be Used Within 6 Months of the Date of Purchase. Initial Here_____