



Consent for Treatment of Varicose Leg Vein(s)

You have come to our office to have our physicians evaluate and seek to remedy the varicose vein condition in your leg(s). The selected procedure felt best to address your condition is:

- Endovascular vein ablation by laser
- Ambulatory phlebectomy
- Sclerotherapy

Some of the possible risks include:

1. The appearances of the veins may not improve. However, over 90% of patients see improvement.
2. Brown spots may appear that look like bruises after the treatment. These areas may take several weeks to months to go away. It is rare for this discoloration to be permanent.
3. Tenderness, bruising, or a firmness in the treated area may last for various periods of time. This can be minimized by the use of support hose after the treatment.
4. Sometimes blood may accumulate in the larger veins treated. These accumulations may be treated by subsequent procedures by trained physicians to decrease any discomfort. Strict use of support hose minimizes this possibility.
5. Rarely this accumulation of blood may form a clot. Although this is usually trapped in the superficial vein and causes no problem, there is a rare possibility of phlebitis.

PATIENT CONSENT

I understand that medicine is not an exact science, and that even though the vast majority of patients are satisfied with their results, there is no guarantee I, myself, will be satisfied with the improvement of my varicose veins after treatment. I acknowledge that the following topics have been explained to me, and that I understand the explanations I was given. I have had the opportunity to ask any questions. In particular, I am familiar with the following information:

- The various techniques that can be used for treating diseased veins
- The option to do nothing about my vein problem
- Risks & potential complications
- Inflammation or trapped blood
- Recurrence of varicosities
- Skin ulcers
- Benefits of treatment
- Bruising & discoloration
- Allergic reaction to medication or tape
- Skin staining (hyperpigmentation)
- Telangiectatic matting

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 possibility for my own treatment. I understand that I am responsible for my own medical bills. I understand that unless otherwise agreed, I must pay my bill in full at the time of each visit. If this medical practice agrees to accept initial insurance assignment for some portion of my medical care, I authorize this medical practice to submit bills to my insurance company and to receive reimbursement directly from my insurance company. I am responsible for possible "co-payments" and/or the difference not paid by my insurance company.

Signed: _____ Date: _____ Witness: _____