GASTROENTEROLOGY AND NUTRITION SPECIALISTS

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Hemorrhoid Banding

I understand and acknowledge, that during the course of my treatment today that the following procedure(s) may be required;

An anoscopy, rigid proctosigmoidoscopy, the banding of a hemorrhoid, the removal of an anal lesion and/or the treatment of the anorectum with possible use of local anesthesia,

Prophylactic treatment with antibiotics.

I acknowledge and understand that prior to any procedure being performed more specific instructions will be given to me. A diagnosis will be explained and I will have an opportunity to ask questions and have those questions answered. The procedure will proceed only when a verbal informed consent and this written informed consent have been obtained.

RISKS

I understand that the practice of medicine is not an exact science and acknowledge that I have not received any guarantees, assurances, or promises concerning the results of the procedure(s). I understand that as a result of the performance of the procedure(s) there is a moderate risk that I may suffer infection, allergic reaction or loss of blood.

The potential benefits and likelihood of success with treatment are very good. I understand and acknowledge that there are alternatives to treatment such as (but not limited to) invasive surgery, infrared coagulation, over the counter (OTC) medications and not seeking treatment (i.e. living with the condition(s). If the procedure is rejected, the future prognosis is unknown at this time.

I acknowledge and understand that during the course of the procedure(s), conditions may develop which may reasonably necessitate an extension of the original procedure(s) or the performance of procedure(s), which are unforeseen, or not known to be needed at the time this consent is obtained and that my treating physician will not be held responsible for any unforeseen circumstances.

I acknowledge and understand that this request for and consent to surgical and/or diagnostic procedures shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the physician, and for all other medical personnel otherwise involved in the course of treatment.

By signing below, I have read this form and had this form read and/or explained to me and that I fully understand this form, and I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner, In signing, I understand the relative risks, potential benefits and alternatives for hemorrhoidal therapy and I voluntarily consent to allow Dr._____ or any physician designated or selected by them and all other personnel that may otherwise be involved in performing such procedures, to perform the procedures described or referred to herein,

_____ _____
Signature of Patient or Person Signing on Behalf of Patient Date/Time

_____ _____
Signature of Witness Date/Time