



Phone (302) 731-0001

Fax (302) 731-0040

INFORMED CONSENT FOR VASCULAR PROCEDURE

I hereby authorize Dr. Anthony Alfieri to treat my saphenous vein(s) using an endovenous (mechanical or radiofrequency) ablation technique and/or ultrasound guided sclerotherapy.

Dr. Anthony Alfieri has explained that common symptoms of varicose veins, such as heaviness and pain after standing for a long time, arise from malfunctioning valves in the saphenous vein (the main superficial system vein in the thigh and calf). Satisfactory treatment of varicose vein symptoms is usually achieved by closing the saphenous vein. Although treatment of the saphenous vein using the ablation procedure should reduce the pressure in my varicose veins and thus relieve many of my symptoms, I understand that this procedure for treatment of my saphenous vein does not include actual removal of the varicose veins, which may still be visible after the procedure.

I also understand that my insurance company may not approve reimbursement for this procedure without a prior authorization. To the best of my knowledge, the Delaware Advanced Vein Center Staff will contact my insurance company to obtain the appropriate authorization for this procedure, if needed.

The general nature of the ablation procedure for treatment of the saphenous vein has been explained to me. I understand that among the known risks of this procedure are: failure to close the vein, numbness and tingling in the treated area, leg swelling, bruising, mild phlebitis, pain, tenderness or redness over the treated vein, skin burns, vessel perforation and pulmonary embolisms that may need to be treated with additional surgery. I am aware that in addition to the risks specifically described above there are other risks that may accompany any surgical procedure, such as intra-operative and post-operative blood loss, infection and clot formation in the venous system, unknown allergic reaction to drugs, which may require additional medication or surgical intervention, as determined by the physician. It is recommended to abstain from air travel 7-14 days from the procedure and a follow up ultrasound be documented prior to travel.

Dr. Anthony Alfieri has not guaranteed either the results of surgery or freedom from potential complications. I have had sufficient opportunity to discuss my condition and proposed treatment with Dr. Anthony Alfieri and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base this informed consent for treatment.

Patient Signature

Date

I understand that by signing this agreement, I am authorizing the provision of therapy for the ablation of the Saphenous Vein or ultrasound guided sclerotherapy, while under the care and supervision of my attending physician, Dr. Anthony Alfieri.

I authorize direct payment of any insurance benefits for the ablation of the Saphenous Vein, to be made directly to my physician, their billing agent, or to any provider of these services. I also authorize my insurance company to provide all information pertaining to my insurance benefits and status of claims submitted for therapy rendered.

I acknowledge that reasonable efforts will be made to have my insurance pay for this therapy. In the event that my insurance will not cover this therapy, I agree to be responsible for the full amount of the charges or any remaining balances due after insurance has paid.

I consent to the release of my medical information to any insurance company for use in determining payment for the ablation of the Saphenous Vein(s). This consent shall be valid for whatever period of time is reasonable, necessary, or until I revoke this consent in writing.

The undersigned certifies the following: that the foregoing text has been read, a copy thereof has been received, and the undersigned is the patient or duly authorized representative of the patient and, as such, is responsible to execute the above and accept its items.

Patient's Name

Date

Patent's Signature

Date



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INFORMED CONSENT FOR NITROUS OXIDE

GENERAL INFORMATION: Nitrous oxide is a colorless gas that is used during medical procedures for relaxation and pain relief. It is a method of conscious sedation which is administered through a nasal breathing mask. Recovery time is generally only a few minutes.

POTENTIAL SIDE EFFECTS: The administration of conscious sedation with nitrous oxide carries certain risks and side effects which, although infrequent, may occur. They include but are not limited to the following: nausea, dizziness, drowsiness, euphoric feelings.

PLEASE NOTIFY the doctor **PRIOR TO NITROUS OXIDE ADMINISTRATION** if you have congestive heart failure, COPD, respiratory disease of any kind, hepatitis B or C, tuberculosis, macrocytic anemia, immune disease, middle-ear infection, claustrophobia or history of substance abuse.

PREGNANCY WARNING: NITROUS OXIDE SHOULD NOT BE ADMINISTERED TO WOMEN WHO ARE PREGNANT. **PLEASE NOTIFY THE DOCTOR IF YOU ARE PREGNANT PRIOR TO NITROUS OXIDE ADMINISTRATION.**

All patients: By my **ACCEPTANCE** below, I certify that I have read and understand the above instructions, risks and warnings. I have informed the doctor of any contraindications listed above.

Females only: By my **ACCEPTANCE** below, I also certify that I am not currently pregnant or suspect that I am pregnant.

PATIENT SIGNATURE

DATE