DISCLOSURE AND CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Patient Name: _____ Date of Birth _____

I understand and acknowledge that during the course of my treatment planned for me today, I (we) voluntarily consent and authorize these procedures:

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

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Dr. _____ as my physician, and such associates, technical assistants and other health care providers as he/she may deem necessary.

I (we) understand that my physician may discover other or different conditions which may require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) 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 minor 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 understand and acknowledge there are instances when information concerning my care, including copies of my medical records and/or billing information pertaining to my medical care, must be used by Dr. _____ or disclosed by Dr. _____ to certain individuals or representatives of agencies or organizations in connection with my care, payment for my care, and other activities related to my care. I also acknowledge that these and other permitted uses and disclosures are more fully described in the Dr. _____ Notice of Privacy Practices.

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 Legal Guardian Date/Time

_____ _____

Signature of Witness Date/Time