HEMORRHOID
TREATMENT CENTER
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Informed Consent for Rubber Band Ligation or Infrared Coagulation of Internal Hemorrhoids by Jay P. Diliberto, M.D.

Patient Name: ..... **Date of Birth:** ..... /..... / .....

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

An anoscopy, the banding of a hemorrhoid, the removal of an anal lesion and/or the treatment of the anorectum with possible use of topical local anesthesia (viscous lidocaine) and an anti-spasm ointment (nitroglycerin 0.4% ointment)

I acknowledge that I have stopped any prescription blood thinners such as Xarelto, Pradaxa, Brillinta, and Eliquis (to name a few).

I acknowledge that I am not allergic to Latex.

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 because 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, over the counter (OTC) medications and not seeking treatment (i.e. living with the condition(s). If the procedure is rejected, the future prognosis off my condition is unknown at this time. If procedure is rejected, my condition may require more invasive and more painful therapies.

I acknowledge and understand that during 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 and for all other medical personnel directly under his supervision and 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. Jay P. Diliberto 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