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# Informed Consent Banding

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Anoscopy, rubber band ligation of hemorrhoid.

**I acknowledge and understand that prior to any procedure(s) being performed, the physician will give me more specific instructions. The physician will explain the diagnosis, and I will have an opportunity to ask questions and have those questions answered. The procedure(s) will proceed only when I have given a verbal informed consent and signed this written informed consent.**

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## **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 minor risk that I may suffer pain, urinary symptoms, loss of blood, infection, or allergic reaction, along with a risk of recurrent hemorrhoidal symptoms.

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 that may reasonably necessitate an extension of the original procedure(s) or the performance of procedure(s) that are unforeseen or not known to be needed at the time this consent is obtained. In the event of such unforeseen circumstances, I consent to my treating physician providing treatment to me that he or she deems medically necessary.

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 acknowledge that I have read this form and had this form read and/or explained to me and that I fully understand this form. I also acknowledge that 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 acknowledge that 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 him or her and all other personnel that may otherwise be involved in performing such procedures, to perform the procedures described or referred to herein. I also acknowledge that I understand and consent to the fact that vendors or other observers may be present during the performance of my procedure(s).

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Signature of Patient or Person Signing on Behalf of Patient

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Date/Time

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Signature of Witness

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Date/Time