



AESTHETICS & WELLNESS

SCLEROTHERAPY CONSENT

This is an informed consent document that has been prepared to help inform you of sclerotherapy injections, its risks, as well as alternative treatments. It is important that you read this information carefully and completely. Please read each page and sign the consent.

My signature and initials after each statement below constitutes my acknowledgment that: I, _____, consent to and authorize Emily Goodrich, nurse practitioner, to perform sclerotherapy injections.

INTRODUCTION

The purpose of this procedure is to diminish unsightly spider veins. The procedure may require more than one treatment and may produce permanent vein removal. The total number of treatments will vary between individuals. On occasion, there are patients that do not respond to treatments.

ALTERNATIVE TREATMENTS

Alternative forms of non-surgical and surgical management for the appearance of veins include laser ablation and surgical procedures. Alternative forms of treatment are all associated with certain risks.

The following complications may occur with the sclerotherapy vein removal system:

- ❖ _____ I understand there is a risk of bruising, burning sensation/pain, blood clots, allergic reaction, hyperpigmentation and temporary cramping. These side effects usually take 1-4 weeks to heal, however pigmentation irregularities can take up to six months to heal.
- ❖ _____ Infection: Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
- ❖ _____ Effectiveness: While new veins may appear over time, I understand removal can be permanent.
- ❖ _____ Treatments: I understand removal of veins will take several treatments.
- ❖ _____ Allergic Reactions: In rare cases, there may be an allergic reaction to the sclerosing solution.
- ❖ _____ There is a risk of scarring.
- ❖ _____ I will follow all aftercare instructions as it is crucial I do so for healing.

Should complications occur, other treatments may be necessary. Even though risks and complications occur infrequently. Although good results are expected, there cannot be any guarantee or warranty expressed or implied with regard to the results that may be obtained.

I hereby authorize the nurse practitioner to perform the procedure of sclerotherapy injections. I hereby release my nurse practitioner, the facility and the doctor from liability associated with this procedure.

My signature below acknowledges that I have read and understand the content of this informed consent. I have been given ample opportunity to ask questions, all of which have been answered in a satisfactory manner. I understand that results can vary and that no guarantee, neither expressed nor implied, has been or will be, given to me regarding my results. I'm aware of the risks and benefits associated with the procedure, as well as available alternative treatments. I understand that this is an elective procedure, performed solely for cosmetic purposes, and is not critical to my health. On my own free will, I am requesting and providing my informed consent, to undergo this procedure. I assume all risks as my own and agree to hold harmless, Aria Aesthetics and Wellness, PLLC and their providers, and any other staff member, affiliate, or independent contractor. I hereby release them from any liability, both seen and unforeseen, now and forever.

Patients or Legal Guardian's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____