Hemorrhoid Energy Treatment (HET) Consent

I consent to having Hemorrhoid Treatment by HET.

Hemorrhoid Energy Treatment is performed to treat hemorrhoids. It is efficient and well tolerated by most patients, and has limited side effects. The hemorrhoids are treated with ligation technology which coagulates the veins above the hemorrhoid causing it to shrink and recede.

I understand there are risks associated with HET treatment, such as rectal pain, hemorrhoid thrombosis or bleeding, and/or anal fissure or anal abscess.

Dr. _____ has explained the procedure and its risks to me, along with alternative diagnosis and treatment. I have been allowed to ask questions and have received answers to my questions concerning the planned examination.

I authorize the performance of the following procedure by or under the direction of the following physician. I have read and fully understand this consent form, and understand I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

I consent to the taking of any photographs during my procedure to assist in my care and for use in the advancement of medical education; for the presence of an observer during the procedure to provide assistance or consultation services to the physician. I certify that I understand the information regarding deep sedation. I have been fully informed of the risks, benefits, alternatives and possible complications of my procedure/anesthesia.

I understand that I have been advised that I should not drive for twelve (12) hours following my procedure. I also understand that in the event of cardiac or respiratory arrest or other life threatening situation during my admission, the Center will perform necessary life saving measures until transferred to a hospital should such methods become necessary and that my Advance Directives will not be honored at LICDH. I give my consent for any medical treatment deemed necessary including transfer to a higher level of care.

I consent to the drawing and testing of my blood in the event that an individual is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential, expect as specified by law.

I consent to having a peer physician review my medical record to obtain information about the delivery of medical care.

Physician explaining procedure: _____M.D.

Signature: _____M.D.

Date: _____

If any unforeseen condition arises during the procedure calling for, in the physician's judgment, additional procedures, treatments, or operations, I authorize him/her to do whatever he/she deems advisable. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of this procedure. If there is any question that I might be pregnant, I will allow a urine pregnancy test to be performed prior to my procedure.

_____ _____

☐ **Patient /** ☐ **Legally Authorized Representative** (check one) **Relationship to Patient**

Date:_____ **Time:** _____ **Witness of Signature only:**_____