

SCLEROTHERAPY INFORMED CONSENT

I, _____, authorize Steven Tidwell, M.D. and/or Heidi Garguilo, ARNP to perform Sclerotherapy and/or cutaneous laser YAG treatment for telangiectasias (spider veins) and reticular veins. I have been informed of the reason for the treatment/procedure(s) along with the expected benefits, risk, possible alternative methods of treatment, and possible consequences involved such as reddening, mild burning, temporary bruising and discoloration of the skin, as well as the rare side effect of skin ulceration.

The treatment/procedure was explained to me in detail and all my questions were fully answered. Understanding this, I authorize the above named doctor and/or nurse practitioner to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for me (or _____).
(Name of patient, if minor)

I understand that multiple treatments may be necessary to obtain optimal results, which vary from person to person. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I understand that the treatment involves payment and the fee structure has been fully explained to me.

I understand that there are other options for treatment available and each of these options were fully explained to me.
_____ *(Please initial)*

This office is a doctor's office regulated pursuant to the rules of the Board of Medicine as set forth in Rule Chapter 64B8, F.A.C.

RELEASE OF MEDICAL RECORD

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

PHOTOGRAPHS

I do ___ do not ___ give my permission for photographs and other audio-video and graphic materials to be used by Medicus VeinCare for marketing, educational – promotional purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

Signature: _____

I read and understand this agreement. My questions were answered to my satisfaction. I agree to the terms of this agreement.

Patient Name *(print)*: _____

Signature: _____

Witness: _____

Date: _____

Steven Tidwell, M.D./Heidi Garguilo, ARNP, BC