

CAPITAL VASCULAR SURGEONS & VEIN CENTER
3855 J STREET
SACRAMENTO, CALIFORNIA
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I will be undergoing sclerotherapy, a procedure that involves the injection of chemicals into the veins of my leg(s). The intent of this consent is to create an understanding between the provider and the patient as to the methods and risk involved in treatment of spider veins.

I understand the treatment(s) to be for the purpose of elimination of spider veins. Spider veins can be a chronic and recurrent condition. This treatment modality will not offer a cure but rather control of the condition. Your tendency to develop new spider veins will not be relieved by this or ANY other form of treatment. Our aim is to give you improvement of your recurrent condition.

It should be understood that sclerotherapy treatments may need to be repeated several times before satisfaction is achieved. It should be understood that Capital Vascular Surgeons & Vein Center will do what is appropriate in the treatment of your condition but that you may be required to wear compression stockings for a minimum of 5 weeks.

1. The total duration of the treatments will vary based on the size of the treatment area and the procedure being performed.
2. That photographs of the treatment area will be taken for my medical record and for future comparison.
3. I will need to follow instructions but not limited to the use of compression stockings after treatment.

I understand the following risks and benefits of the procedure include but are not limited to :

Superficial clot formation and inflammation at the treatment site.
Pigmentary color changes at the treatment site(s).
Recurrence of vessels, spider veins at the treated sites.
Allergic reaction to the sclerotherapy agent.

I understand this treatment is entirely voluntary on my part. I understand that there will be a charge for this and all consecutive treatments unless arrangements have been made otherwise. The charge for consultation is \$ 85.00 and the charge for the sclerosant is \$300 per 3cc syringe. My signature indicates that I have decided to receive the treatment, having read and understood the information presented above and having been given the opportunity to ask questions of both Dr. Ward and Kerrin Dietrich that I may have about the procedure.

Patient Signature

Print Name

Date

Witness

Print Name

Date