Stacey Folk, MD
303-321-6608
www.FolkPlasticSurgery.com

CONSENT FOR SCLEROTHERAPY INJECTIONS

I authorize Dr. Stacey Folk and her staff to perform sclerotherapy on myself to destroy unwanted leg veins.

Other methods of treatment, as well as the consequence of no treatment, have been discussed with me.

I am not currently pregnant, breastfeeding, nor do I have a personal history of asthma or blood clots in the legs or lungs.

Possible complications of injections include, but are not limited to: allergic reaction to the medication, scarring, ulcerations, open wounds and deep vein thrombosis (blood clots in the legs). These are rare but possible complications of this procedure. An even rarer complication could be pulmonary embolism. If you experience any reaction, symptom, or have any concern, please call our clinic immediately.

Possible complications of laser therapy include, but are not limited to: redness, swelling, bruising, blistering and discoloration. Pigment changes are rarely permanent.

Depending on the size and location of the veins being treated, complete resolution may not be possible or may require multiple treatments. An average of three treatments is necessary for most people; you may require more or less treatments.

Anesthesia is not necessary and will not be used.

I understand this is a strictly cosmetic service and will not be billed to insurance.

I consent to taking of photographs during the course of treatment for the purpose of medical education and/or marketing, including but not limited to, website information.

I understand that special dressings are to be worn for 72 consecutive hours post-injection and failure to follow post-procedure directions may result in sub-optimal results.

I have read and understand all information presented to me before signing this consent. A copy of this consent will be provided to me at my request.

I CONSENT TO THE TREATMENT OF SCLEROTHERAPY INJECTIONS AND I HAVE READ THE ABOVE LISTED ITEMS. I AM SATISFIED WITH THE INFORMED CONSENT PROCESS

_____ _____
Patient or Person Authorized to Sign for Patient Date

_____ _____
Witness Date