

It is very important to the physicians of **REGIONAL GASTROENTEROLOGY ASSOCIATES OF LANCASTER, LTD.**, that you, our patient, understand the treatment we are rendering and any invasive procedure which we may, with your agreement, perform. We want to involve you in any and all decisions concerning invasive procedures which you may need to have performed. We take "informed consent" very seriously in our office. Therefore we only want you to sign this form when you understand the procedure to be performed, you understand the risks associated with the procedure, alternatives to the procedure, the risks associated with those alternatives, and all of your questions have been answered.

I, _____, hereby authorize Drs. Altman, Colton, Connell, Devenyi, Elkin, Foley, Gibas,
(Patient Name) Lalani, Lazarus, Lomboy, Pokorney, Rosenberg, Smith and/or Whitebloom to perform infrared coagulation of my hemorrhoids.

The purpose of infrared coagulation is to shrink hemorrhoids and alleviate bleeding and pain.

No guarantee or assurance has been given to me that the proposed procedure will be curative and/or successful to my complete satisfaction. However, it is the physician's opinion that it will be helpful to my condition. In that no guarantee as to the uneventful success of this procedure has been given, I also authorize any further procedure which, in the physician's judgment, needs to be done because of any unforeseen condition which arises during this procedure.

I also authorize when appropriate the use of a sedation or anesthesia during the procedure which, in the physician's judgment, may be necessary or advisable for my comfort, well-being and safety.

The physician (or the physician's assistant or other mid-level provider) has fully explained to me the risks and complications inherent with this procedure which include, **but are not limited to**, rectal pain, bleeding potentially requiring transfusion, perforation of the bowel wall and infection. I understand and accept that any of these complications could lead to further hospitalizations and surgical procedures for their corrections and, although it is very rare, could lead to my death.

Alternatives to this procedure, along with the risks of those alternatives, have been explained to me by the physician (or the physician's assistant or other mid-level provider). Alternatives include, **but are not limited to**, medical therapy, surgery and continued observation.

I understand that if I have been given medication to relax, I will not be able to operate a vehicle for the remainder of the day the procedure is performed. Further, I have received and reviewed the patient instruction sheet with respect to the procedure.

I have had an opportunity to ask the physician (or the physician's assistant or other mid-level provider) all questions concerning the procedure, risks, complications, alternatives, and risks of those alternatives. All of my questions have been answered to my satisfaction.

Patient's Date of Birth

Patient's Name (please print)

Date

Signature of Patient / Parent or Guardian

Date

Witness to Patient's Signature Only

Date

Physician Signature