Consent for
Ambulatory Phlebectomy

Patient Name (Please Print)_____ Date_____

Nature and Purpose of Vein Surgery

I hereby authorize Dr. Polly Kokinos to extract or interrupt my bulging unsightly veins for the purpose of attempting to improve the appearance of my legs. I understand that no authorization and/or reimbursement claim is submitted to my insurance company. This procedure is considered cosmetic in nature and is not covered by any insurance.

_____ **(initial)**

Although many of the visible varicosities will be removed with phlebectomy, overlying spider veins or spider veins which may appear later will need to be treated with sclerotherapy. Sclerotherapy is not covered by insurance, and patient will be responsible for the cost of that additional treatment. Compression hose is also recommended after surgery and will need to be purchased at the time of surgery. This office will not submit sclerotherapy or compression hose to insurance.

_____ **(initial)**

Alternatives

I understand that alternative treatments for varicose veins do exist. These alternative treatments include: conservative therapy (with support and compression hosiery), Sclerotherapy (injection of sclerosing agents into diseased veins), and surgical procedures such as ligation (cutting or tying the vein in the groin or behind the knee) and stripping (pulling a long segment out).

_____ **(initial)**

Risks and Complications

Ambulatory phlebectomy adequately and satisfactorily removes varicosities of different sizes and results in a series of very acceptable micro incisions that are pleasing to the patient and surgeon. The entire procedure can be performed under local anesthesia on an ambulatory basis in all except the most severe and complicated cases.

Nonetheless, complications do result and must be appropriately treated. Complications of ambulatory phlebectomy include, but are not limited to: bleeding, superficial thrombophlebitis (inflammation of superficial veins), deep venous thrombosis (deep blood clot), pulmonary embolism (blood clot in the lung), telangiectasias (spider veins), edema (swelling), infection, transitory or permanent pigmentation (discoloration of the skin), eczema, scarring, dimpling, and rarely neurological complications such as nerve damage. Complications of the use of compression bandages include swelling and blisters.
I am aware that, in addition to the risks specifically described above, any surgical procedure may

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be accompanied by blood loss; infection; inflammation in the deep venous system, with formation of thrombus (clot); intra- and post-operative bleeding; nerve trauma that may lead to temporary numbness.

_____ **(initial)**

Anesthesia

I consent to the administration of anesthetics by either Dr. Polly Kokinos or under her direction. I am aware that the use of local anesthesia involves risks such as allergic reaction or toxic reactions to the anesthetic and cardiac arrest.

_____ **(initial)**

Proposed Treatment

I know that the practice of medicine and surgery is not an exact science, and therefore, reputable practitioners cannot guarantee results. No guarantee has been given to me by anyone as to the results that may be obtained. I understand that especially as I have had these treated multiple times before, that it is possible that these will return again within a period of months/years. This is something that cannot be predicted or prevented.

I have had sufficient opportunity to discuss my condition and proposed treatment with Dr. Polyxene Kokinos and/or her associates, and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge on which to base an informed consent to the proposed treatment.

I hereby authorize Polly Kokinos, or her associated staff, to perform any other treatment that may be deemed necessary should an unforeseen unhealthy condition be encountered during the course of the procedure.

_____ **(initial)**

Cooperation and Follow Up

I agree to keep Dr. Kokinos, and/or her associates and staff, informed of any changes in my permanent address, and agree to cooperate with them in my post-treatment care. I agree to follow up with Dr. Kokinos as recommended.

_____ **(initial)**

Photographs

I hereby give my permission to Dr. Polly Kokinos, MD, or any of the medical personnel at South Bay Vascular Center and Vein Institute, to take photographs of all treated sites for diagnostic purposes and to accurately document the medical record in the usual and customary manner. I agree that these photographs are the property the South Bay Vascular Center and Vein Institute and my photographs can be used for teaching purposes, to illustrate scientific papers, books or for use in general lectures. It is specifically understood that in any such publication or use, my photographs shall not be by name.

_____ **(initial)**

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Informed Consent

I voluntarily request treatment of my leg veins by Polyxene Kokinos, MD using ambulatory phlebectomy. This procedure has been explained to me, and my questions regarding such treatment, its alternatives, its complications and risks have been answered by the doctor and/or her staff. The information which I have been given has been in terms clear to me, and I understand the risks and compliance of the treatments. I hereby give my unrestricted informed consent for the procedure.

_____ **(initial)**

_____ _____

Signature of Patient or Person Authorized to Sign | Date

_____ _____

Relationship to Patient

_____ _____

Signature of Witness | Date

I certify that I have informed the patient of the available altemative(s) to the proposed procedure and of the inherent potential risks, complications, and results that may occur as a result of the said procedure.

_____ _____

Polyxene Kokinos, MD | Date

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