Rochester Gastroenterology Associates, LLC
20 Hagen Drive Suite 330, Rochester, NY 14625
Phone (585) 267-4040 Fax (585) 267- 4044

AUTHORIZATION/CONSENT FOR HEMORRHOID BANDING

I hereby authorize: Prasad Penmetsa, M.D., Surinder Devgun, M.D., Ari Chodos, M.D.,
And whomever he may designate as their assistant, who is referred to as "the Doctor" in the rest of this consent form, to perform the following procedure: Hemorrhoid Banding.

Timeout Completed:_____
Signature Date

For the following condition: **Symptomatic Hemorrhoids**

1. The Doctor has explained the condition and procedure to me. He has explained the purpose of the procedure and alternate ways of treating the condition.
2. In addition to the usual risk of these procedures, I have been made aware of certain risks, and consequences that are associated with the procedure. These include but not limited to: bleeding, infection, pain etc.
3. I understand that during the procedure, the Doctor may discover a condition that he did not know about or was not recognized before the procedure started. Therefore, I authorize the doctor or his assistant to perform and additional or different procedures.
4. At the discretion of the Doctor, I consent to the presence of manufacturer's representative to aid in the proper use of the equipment.
5. I understand the Doctor may have assistants participate with him, under his supervision, in this procedure.
6. I understand that no guarantees are made to me about the results of this procedure.

I HAVE READ THIS FORM. I UNDERSTAND WHAT IT MEANS.

_____ _____
Patient Signature Date Witness Date

_____
Doctor's Signature Date