INFORMED CONSENT FOR REPAIR OF NASAL VALVE COLLAPSE

Dr. Don J Beasley, MD
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208-229-2368

Account# ______________________________

Patient Name: ____________________________ Date of Birth: ____________________

Because all individuals are different, some individuals are better suited for the ClariFix treatment than others. Most patients will receive an improvement in their chronic rhinitis symptoms, while others may have little or no improvement.

Results can be affected by several factors, including the type of chronic rhinitis (i.e. allergic vs non-allergic) with which you present, your nerve anatomy and whether your symptoms are multifaceted. It is also possible that additional treatments may be required.

Before the ClariFix treatment, a local or topical anesthetic will be applied to the treatment area. You may feel pressure and hear a hissing sound during the treatment.

You may experience an acute “ice cream” headache or pain in your jaws or temples as a result of the cryotherapy. This typically resolves spontaneously within an hour of the treatment. Over-the-counter Tylenol may be taken as needed.

After the treatment, you may experience reactions commonly associated with healing after cryosurgery in the nasal passageways, including but not limited to an increase in nasal congestion, facial pain, bleeding, dry nose, or ear blockage.

The most common side effects associated with the ClariFix treatment are temporary increased nasal congestion and transient discomfort or pain, including headaches.

Complications — You may experience one or more of the following symptoms related to cryosurgery. Some symptoms may be mild or transient in nature and self-resolving. These can include but are not limited to:

- Mild swelling
- Frost-bite and/or Cryolysis to surrounding area
- Delayed diagnosis due to change in pain perception or presentation on clinical or imaging assessment
- Excessive freezing may cause tissue damage

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I am aware that other unexpected risks or complications may occur and that no guarantees or promises have been made to me concerning the results of the treatment.

My questions regarding this treatment, its alternatives, its complications and risks have been answered by my doctor and/or his or her staff. I have read this form and understand it, and I request the performance of the treatment.

I consent to the photographing, filming, or videotaping of the treatment or procedure for educational or diagnostic use.

I do not wish to have any photographing, filming, or videotaping of the treatment or procedure for any use.

Patient Signature: ____ Date: ___________________________

Witness Signature: _______________________________________ Date: ___________________________