Transform weight loss

Seattle Clinic Kit

FRONT DESK · ENQUIRIES · PATIENT MATERIALS

A reference pack for the team taking the calls: how to answer the questions patients actually ask, what can and cannot be said, and how to tell a good fit from a polite pass.

DRAFT FOR REVIEW · AUGUST 2026

Within 1 hr	14	~87%	4
FIRST HUMAN CALL	QUESTIONS ANSWERED	SYMPTOM-FREE AT 5 YRS*	CHECKS BEFORE BOOKING

01 · START HERE

How to use this kit.

The clinic runs its own enquiries, its own systems, and its own schedule. Nothing here changes that. This is reference material for the people answering the phone, written to be adapted rather than followed exactly. Take what is useful and ignore the rest, with one exception: page 04 is the compliance page, and that one is firm.

GUARDRAIL

Nothing here reaches a patient until the clinic signs off. All patient-facing language and every clinical claim goes through the clinic's own medical and legal review. This kit is a draft written to make that review quick.

FOR REVIEWERS

Leaving comments on this draft.

Highlight any text, or click any image, on any of the six pages. Comments save to the server as you go, and the page and section are recorded automatically.

HOW TO LEAVE A COMMENT

1. **Select the text you want to comment on,** or click an image. A `Comment` button appears.
2. Press it, type your comment, and hit `Enter`. That's it.

No name to fill in, and nothing to save. Every comment is stored the moment you post it, and we can read them from our side at any time.

To send them on anyway, click `Export comments` in the left sidebar for a single file covering all six pages.

The `Comments` button in the bottom corner lists everything left so far, where you can also reply or archive anything already handled.

WHAT A GOOD ENQUIRY LOOKS LIKE

The four-point check.

Before spending real time on someone, this is what is worth confirming. It takes about thirty seconds, and it is the same list whether the enquiry arrived by phone, by web form, or as a referral.

- [ ] **A real, reachable person**
  A working phone number or email, and a name that is not obviously junk. One verification attempt is enough before marking it spam.

- [ ] **Willing to travel to Seattle**
  Where they live does not matter. Whether they will come to the clinic does. People travel for a procedure like this, so ask rather than assume.

- [ ] **Commercial insurance, or able to self-pay**
  The clinic cannot bill Medicare or Medicaid, so it is kinder to say so early than to let someone get their hopes up.

- [ ] **Has symptoms, and wants them treated**
  Someone still researching is worth keeping warm, not chasing. Someone who wants this dealt with is worth a consult time today.

All four yes → offer a consult. Whether the procedure actually suits them is the surgeon's call at the consult, never a judgement made on the phone. The full triage, including how to close the ones that are not a match, is on page 02.

TWO ANSWERS ONLY THE CLINIC HAS

Fill these in before the team goes live.

Two questions come up on almost every call, and both are clinic decisions rather than something this kit can answer. They may even differ from one location to the next. Write the answers in, and the scripts on the other pages work as they stand.

CLINIC DECIDES

What is the anesthesia approach here?

Drives the honest answer to the most common question of all, **"does it hurt?"**, and what to say about recovery. Better to say nothing than to promise comfort the clinic cannot stand behind.

OUR ANSWER

CLINIC DECIDES

Which plans are accepted, and what is the self-pay rate?

Patients are told the clinic takes commercial insurance and offers self-pay. The team needs the accepted-plan list and the self-pay figure to answer cost questions with any confidence.

OUR ANSWER

ANYTHING ELSE TO SETTLE

Questions, corrections, and anything this kit gets wrong about how the clinic actually runs.

WHAT'S INSIDE

Six pages, one job: more booked consults.

02 · CONVERT

Lead flow & qualifying

A response cadence built for a busy desk, and the four checks that decide who gets the follow-up time.

03 · CONVERT

Question battlecard

The 14 questions callers ask most, with suggested wording for each in plain, compliant language.

04 · COMPLY

Say / don't say

Approved language, the words never to use, and what must never be promised. The firm page.

05 · PATIENT

Patient materials

The one-page handout for the front desk, plus the tri-fold brochure concept.

06 · LEARN

Hemorrhoid education

Symptoms, the words patients use, and every treatment option with where ours sits among them.

WORTH DOING ONCE THE PHONES ARE BUSY

Ideas, for whenever there's room.

None of this is required, and none of it matters in week one. It is the short list of habits that tend to make the next few months easier.

Track the questions

Keep a running note of what callers actually ask. Anything that comes up three times belongs on the battlecard, and the team should send it over so the kit gets updated.

Ask after recovery

A short check-in a week or two after the procedure tells the clinic how patients are really doing, and catches anyone who needs attention sooner.

Ask for the review

Patients who are glad they came will happily say so, but usually only if asked. The best moment is right after a good follow-up, never before.

Note where they heard about it

One line at the end of the first call. Over a few months it shows which referral sources are actually working.

Log the passes

The reasons enquiries are turned away are as useful as the bookings. A pattern in the passes usually points at something fixable.

Keep the handout stocked

The one-pager on page 05 is meant to leave with the patient. It works hardest at the front desk, not in a drawer.

THE ONE HABIT

Answer early, answer honestly, book the right patient.

Fill in the two answers above and the rest of this kit works as it stands. Start with lead flow.

*From the published study on the procedure. See page 05 for the figure and citation.

02 · REACH AND QUALIFY

Catching people while they're still looking.

Two things decide whether an enquiry becomes a booked consult: getting back to someone before they move on, and spending the follow-up time on the people it can actually help. This page covers both. All of it is a starting point to adapt, not a script to follow to the letter.

WHERE ENQUIRIES COME FROM

However they arrive, the clock starts at capture.

The clinic decides how enquiries come in and which tools carry them. Whatever the channel, the moment someone's details are captured is the moment the follow-up window opens.

Phone

Someone calls the clinic directly. If it is answered live, the conversation and the qualifying happen together.

Web enquiry

A form or request on the clinic's own site, landing wherever the clinic routes it.

Referral or walk-in

A physician referral, an existing patient asking about it, or someone who walks in.

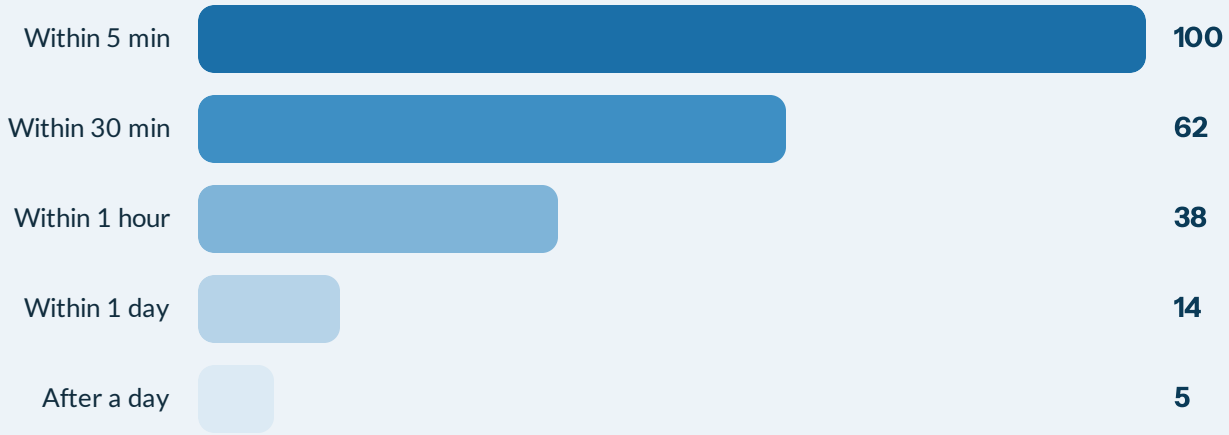
The clock starts when the enquiry is captured, by form, phone call, referral, or any other route the clinic chooses. Everything below is measured from that moment.

CONFIRM: IS THIS THE INTENDED SET-UP

THE CASE FOR GETTING BACK QUICKLY

The first hour counts for a lot.

Relative chance of reaching someone, by how soon the clinic gets back to them.



WHAT IT MEANS IN PRACTICE

The curve is steep at the start and flat after that, which is the useful part: **an instant acknowledgment plus a call within the hour captures most of the benefit**. Nobody has to drop what they are doing within five minutes for this to work. Illustrative of the established speed-to-lead pattern, not clinic data.

A WORKABLE CADENCE

Built for a desk with other jobs to do.

Written for a front desk covering several procedures, with nobody assigned to this one full time. The automated first touch does the time-sensitive work so a person does not have to.

STRAIGHT AWAY

Automatic acknowledgment

A text or email fires on capture without anyone doing anything. It thanks them, confirms a real person will be in touch, and gives a number if they would rather reach out first.

WITHIN THE HOUR

First human call

Whenever the desk next comes up for air, ideally within the hour and the same day at the latest. After hours, first thing the next morning.

DAY 1 TO 3

Two more attempts

If the first call does not connect, try once more on a different channel, then a third time a day or two later. Different people answer different channels.

DAY 5 TO 7

One friendly close-out

A last note saying the door is open. After that, longer-term follow-up beats dropping someone entirely.

IF THE CLINIC ONLY SETS UP ONE THING

Make it the **automatic acknowledgment**. It is the piece that genuinely has to happen fast, it costs nothing once configured, and it buys the desk an hour it does not currently have.

WHAT THE FIRST TOUCH SOUNDS LIKE

Warm, short, and an easy next step.

Of course, ask us anything. The best way to get answers specific to you is a short consult, with no obligation. Would you like us to hold a time this week?

Three things that tend to work

Warm before clinical

Opening with a person and a thank-you lands better than a pitch. This is a sensitive topic.

Always an easy next step

It helps when every message ends with a specific, low-pressure invitation to book.

Keep it short

A few lines is plenty. The first touch is aiming for a conversation, not a decision.

Wording for the acknowledgment, voicemail, text and email

Automatic acknowledgment (fires on capture): "Hi [first name], thanks for getting in touch with the Transform clinic in Seattle. Someone from our team will call you shortly. If it's easier, reach us any time on [number]."

Voicemail (first call): "Hi, this is [name] with the Transform clinic in Seattle, returning your enquiry about treatment. I'd love to answer your questions and, if it's a fit, help you find a consult time. I'll send a quick text too. Reach us at [number]."

Text (same day): "Hi [first name], it's [name] at the Transform clinic in Seattle. Happy to answer questions or hold a consult time for you this week. When's a good moment to talk?"

Email (same day): Short subject ("Your consult request"), a one-line thank-you, two or three consult times offered, the clinic address, and an invitation to ask anything. Save the patient handout for after they reply, not before.

Day 5 to 7 close-out: "Hi [first name], I don't want to crowd your inbox. We're here whenever you're ready, and a consult is the best way to get answers specific to you. Just reply and I'll take care of the rest."

Four quick checks on every enquiry.

A thirty-second read that protects the desk's time for the people this can help. Fit itself is always confirmed by the surgeon at the consult.

1. **Are the contact details real and reachable?** — No → mark spam, stop
2. **Willing to travel to the Seattle clinic?** — No → polite pass
3. **Commercial insurance or able to self-pay (not Medicare / Medicaid)?** — No → polite pass
4. **Has symptoms and wants treatment?** — Not yet → nurture

✓ **All four yes → offer a consult**

ON GEOGRAPHY

Where someone lives does not matter. Whether they will come to Seattle does. Patients travel for a procedure like this, so the only question is whether they are willing to make the trip, not which state they are starting from.

THE 30-SECOND TRIAGE

Book, nurture, or pass.

BOOK NOW

Move straight to holding a consult time.

- ✓ Will come to the Seattle clinic
- ✓ Describes symptoms and wants them treated
- ✓ Has commercial insurance, or is fine with self-pay
- ✓ Gives a real phone or email, will talk times

NURTURE

Interested but not ready. Keep the door open.

- ~ Wants to think it over or check their schedule
- ~ Still comparing options or researching
- ~ Needs to sort out timing or budget first
- ~ Reachable and warm, just not booking today

POLITELY PASS

Not a fit. Close kindly, free up the time.

- × Can only proceed with Medicare or Medicaid
- × Not willing or able to travel to Seattle
- × Spam, prank, or no real contact details
- × Unrelated or urgent medical issue

Kind, brief, and logged.

MEDICARE OR MEDICAID CALLER

> *I want to be upfront so I don't waste your time. We accept commercial insurance and offer self-pay, but we aren't able to bill Medicare or Medicaid. I'm still happy to answer general questions, and if anything changes we'd love to help.*

Warm, no pressure. Log it as a polite pass with the reason, so the clinic can see how many enquiries are lost this way.

SPOTTING AND HANDLING SPAM

- ✕ Gibberish name, fake or unreachable number, off-topic message
- ✕ Bulk or duplicate enquiries in a short window
- ✕ Requests with nothing to do with treatment
- ✕ **Action:** one quick verification attempt, then mark spam and stop. Don't keep chasing.

Edge cases: distance, urgent symptoms, and "just researching"

- **A long way away but eager:** treat them as Book now and note the travel plan. Distance is a logistics question, not a disqualifier.
- **Urgent or alarming symptoms:** if a caller describes severe pain, heavy bleeding, or anything urgent, don't book a routine consult. Advise prompt medical care and flag it to the clinical team.
- **"Just researching":** that's a Nurture, not a pass. Offer the patient handout, answer a question or two, and invite them to book whenever they're ready.
- **Already had banding that didn't hold:** often a strong consult candidate, and usually a frustrated one. Log what they had and roughly when.

Optional: stages, if the clinic wants to track this in a CRM

Only worth doing if the clinic already runs a CRM and wants to see where enquiries fall away. A simple set of stages that maps onto the triage above:

- **New** — captured, not yet worked.
- **Qualified** — clears the four checks.
- **Reached** — an actual conversation has happened.

- **Consult booked** — on the calendar.
- **Treated** — procedure done, plus whatever follow-up the clinic runs.

If the clinic would rather keep this in whatever system it already uses, that is completely fine. The one thing worth capturing either way is the **disposition and the reason**, so the pattern in the passes becomes visible over time.

Answer early, then spend the time on the people it can help.

An automatic first touch buys the hour. The four checks protect the rest of the week.

03 · ANSWER THE QUESTIONS

The question battlecard.

The 14 questions callers ask most, with suggested wording for each. Use it close to word for word or adapt it to your own voice, as long as it stays honest, plain, and inside what can be claimed. One answer still waits on a fact the clinical lead needs to confirm, and it is marked.

USE THIS ON EVERY CALL · THE CLOSE

"Would you like me to get you on the schedule for a consult? There's no obligation, and it's the best way to get answers specific to you."

Then capture **name, best phone number, and best time to reach them.** The consult is always the goal. Answers exist to remove what's holding someone back, then return to this line.

READING THE CHIPS

A CONFIRM chip marks wording still awaiting clinical sign-off (see page 01). Say only the approved part and book the consult for the rest.

QUESTION 01

What exactly is this procedure?

BEST ANSWER

"It's an in-office procedure for hemorrhoids, **performed by a surgeon, in a single visit**, with published clinical results behind it. The best next step is a short consult to see if it fits your situation."

QUESTION 02

How does it work?

BEST ANSWER

"Thermal energy is applied to the tissue just above the hemorrhoid. **The tissue contracts and the hemorrhoid is drawn back into its normal position.** Nothing is cut or removed."

CONFIRM: MECHANISM WORDING

Corrected against the published paper. The earlier version described closing off a blood-supply artery, which is a different procedure.

QUESTION 03

How is it different from banding?

BEST ANSWER

"Rubber band ligation often **has to be repeated** over several visits. This is a single in-office procedure. In the published study, most patients were still symptom-free five years later."

QUESTION 04

How is it different from surgery?

BEST ANSWER

"A surgical hemorrhoidectomy is effective, but it usually means general anesthesia and a longer, harder recovery. This is an in-office option performed by a surgeon, which is why people ask about it as **the middle path** between repeat banding and surgery."

QUESTION 05 · MOST COMMON

Does it hurt?

BEST ANSWER

"That's the question we hear most. The procedure is done with CONFIRM: ANESTHESIA, and **the surgeon will walk you through exactly what to expect**. I won't promise a specific experience because it varies person to person, but I can tell you what most patients report."

Coaching: never say painless. Honest and warm wins.

QUESTION 06

What is recovery like?

BEST ANSWER

"Many people are **back to their normal routine very soon** after the procedure. The surgeon will give you specifics for your case at the consult."

QUESTION 07

Will my hemorrhoids come back?

BEST ANSWER

"No procedure can guarantee they never return. What I can share is the published evidence: in a study that followed patients for five years, **the large majority stayed symptom-free**."

QUESTION 08

Who performs the procedure?

BEST ANSWER

"**A surgeon performs it**, not a technician or an assistant."

QUESTION 09

Is it FDA approved? Is it safe?

BEST ANSWER

"It's performed by a surgeon, and it has a **peer-reviewed published study with five-year results** behind it, with hundreds of patients treated to date. Safety and your specific situation are exactly what the surgeon will go over at the consult." CONFIRM: REGULATORY WORDING

Coaching: never say "FDA approved" or "FDA cleared", and never paraphrase FDA status. If a caller presses on FDA specifically, that answer belongs to the surgeon at the consult.

QUESTION 10

How much does it cost?

BEST ANSWER

"We accept **commercial insurance plans**, and we also offer self-pay. The consult is where we confirm your coverage and any out-of-pocket cost, with no obligation."

QUESTION 11

Do you take insurance or Medicare?

BEST ANSWER

"We accept **commercial insurance plans**, and we also offer self-pay. We aren't able to bill Medicare or Medicaid."

Coaching: Medicare or Medicaid-only callers are a polite pass. See page 02.

QUESTION 12

Am I a candidate?

BEST ANSWER

"The procedure helps a **wide range of people with hemorrhoids**. The best way to know if it's right for you is a short consult, where the surgeon will review your history and answer everything."

QUESTION 13

Do I have to travel to Seattle?

BEST ANSWER

"Yes, the clinic is in Seattle. **Patients travel to us from well beyond the city**, so it's really a question of whether the trip works for you."

QUESTION 14

Can I see proof it works?

BEST ANSWER

"There's a **peer-reviewed study** published on the procedure. I can send you a plain-language summary, and the surgeon will walk through the evidence with you at your consult."

The summary is the one-page handout on page 05.

Three tone rules that hold the whole card together

- **Honesty beats hype.** Patients with this condition have often been let down before. A measured, truthful answer earns more trust than a big claim, and it keeps us compliant.
- **Answer, then book.** An answer's job is to remove the one thing holding the person back, then return to the consult offer. Avoid long lectures.
- **When unsure, defer to the surgeon.** "That's a great question, and the surgeon will go through it with you at your consult" is always a safe, credible answer, never a failure.

Answer the worry, then come back to "let's get you a consult time."

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04 · STAY COMPLIANT

Say this, not that.

The one page in this kit that is firm rather than suggested, because the rules here come from outside the clinic. Where this page and a sales instinct disagree, follow this page.

WORDS WE NEVER USE

Banned on every channel.

These read as hype or as promises we can't make. They're off the table in calls, texts, emails, and anything written.

~~painless~~ ~~pain-free~~ ~~minimally invasive~~ ~~quick~~ ~~fast~~ ~~rapid~~ ~~revolutionary~~ ~~cutting-edge~~ ~~breakthrough~~ ~~guaranteed~~ ~~cure~~ ~~permanent~~ ~~miracle~~ ~~best in class~~

Swap the instinct for the approved line.

~~"It's painless"~~	→	"The surgeon will explain exactly what to expect"	
~~"Minimally invasive"~~	→	"An in-office procedure"	
~~"Quick recovery"~~	→	"The surgeon will walk you through recovery"	
~~"Revolutionary / cutting-edge"~~	→	"Backed by published five-year results"	

~~"Guaranteed to work"~~ → "Most patients were symptom-free at five years"

~~"It cures hemorrhoids"~~ → "It treats them, with durable results in the study"

THE VOICE

How we talk to patients.

DO

- ✓ Plain, specific language. **Numbers over adjectives.**
- ✓ Be honest that experience varies person to person
- ✓ Empower the patient to decide. No pressure or urgency
- ✓ Treat a sensitive topic with calm dignity
- ✓ Defer clinical questions: "the surgeon will go through that with you"

DON'T

- × Use superlatives or the banned words above
- × Create urgency ("limited spots", "act now")
- × Be euphemistic or crude about the condition
- × Promise outcomes, comfort, or recovery times
- × Diagnose, or paraphrase FDA status

CLAIM SAFETY

Green to say, amber to confirm, red to never.

Safe to say now | Only the approved wording | Never

Green · say freely

In-office procedure, performed by a surgeon, in a single visit. Thermal energy, no tissue cut. We accept commercial insurance and offer self-pay. Peer-reviewed study, hundreds of patients treated, large majority symptom-free at five years.

Amber · approved wording only

The anesthesia approach, and the accepted insurance plans and self-pay rate. Use only the clinic's confirmed wording, once page 01 is filled in. Until then, offer the consult.

Red · never

Painless or pain-free. Guaranteed or permanent. A cure. Promises it won't come back. "FDA approved" or "FDA cleared", or any paraphrase of FDA status. Any claim of being better than a named competitor.

WHEN IN DOUBT

Say less, and book the consult. "That's exactly what the surgeon will go over with you" is always safe, always credible. A booked consult beats a risky claim every time.

Specific over superlative.
Evidence over hype.

One voice throughout: clinically grounded, empathetically direct, never selling.

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05 · PATIENT

Patient materials.

Two pieces for the front desk. A **one-page handout** to give someone on the spot, and a **tri-fold brochure** to leave out for people to pick up. Both are concepts for sign-off, with placeholder photography.

PATIENT DRAFT · PHOTOS ARE PLACEHOLDERS · PENDING CLINICAL REVIEW

THE HANDOUT

One page, handed over in person.

Plain, printable on a single sheet, and written to survive being read in a waiting room or on a kitchen table that evening. It answers the four things people ask before they ask anything else, and it always ends with the clinic's number.

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TREATMENT FOR HEMORRHOIDS

You're not alone, and it's treatable.

Hemorrhoids are very common. Most people just want to feel like themselves again without a big operation or a long recovery. There is an in-office procedure that may be able to help, and this page covers the basics.

- **What is it?**

  A procedure called **thermal submucosal hemorrhoidopexy**. It is performed by a surgeon, in the office, in a single visit. There is no hospital stay.

- **How does it work?**

  Thermal energy is applied to the tissue just above the hemorrhoid. The tissue contracts and the hemorrhoid is drawn back into its normal position. **Nothing is cut or removed.**

- **Does it hurt?**

  Everyone's experience is different, so we won't promise you a particular one. Your surgeon will explain exactly what to expect, and what is used to keep you comfortable, at your consult.

- **Does it last?**

  No procedure can guarantee hemorrhoids never return. In the published study that followed patients for five years, **most remained free of symptoms.**

WHAT HAPPENS NEXT

1. **A consult.** A short appointment where the surgeon examines you, answers everything, and tells you honestly whether this suits your situation.
2. **The procedure,** if it is right for you. A single office visit.
3. **A follow-up,** so we know how you are doing.

A consult carries no obligation. Plenty of people come in, ask their questions, and decide it isn't for them. That's a perfectly good outcome.

Ready to talk it through?

[Clinic phone]

transformweightloss.com

[Clinic name]
[Clinic address]
Seattle, WA

We accept commercial insurance and offer self-pay. We are not able to bill Medicare or Medicaid. This page is general information, not medical advice, and it is not a substitute for an examination. Published five-year results: Sias F, Milone L (2025), *Journal of Surgery*. CONFIRM: CLAIMS REVIEW

HOW THE HANDOUT IS MEANT TO BE USED

Give it to someone **after** a conversation, not instead of one, and write the consult time on it if one has been booked. It is also the right thing to post or email to a "just researching" caller who is not ready to book yet.

THE BROCHURE

The tri-fold, for the waiting room.

A double-sided piece to leave at the front desk for patients to pick up. Both sides are shown as a designed concept so the printed piece is easy to picture.

OUTSIDE · THE SIDE YOU SEE FIRST

INNER FLAP

You're not alone.

Hemorrhoids are common, and they are treatable. Most people just want to feel like themselves again, without a big operation or a long recovery.

Thermal submucosal hemorrhoidopexy is an in-office option that helps a wide range of people do exactly that.

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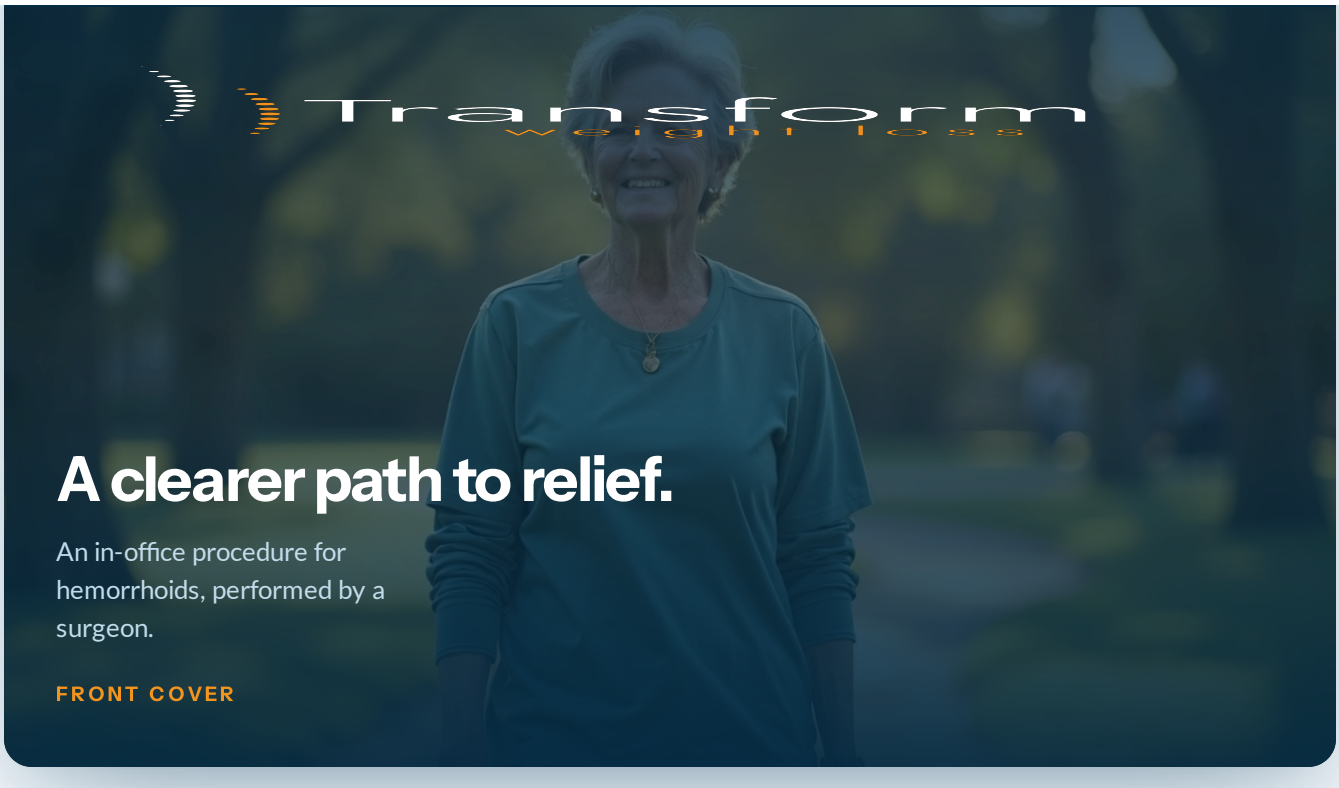
[Seattle clinic name]
[Clinic address]
Seattle, WA
[Clinic phone]
transformweightloss.com

Scan to request a consult



INSIDE · WHEN IT OPENS UP

WHAT IT IS

What is this procedure?

A single in-office procedure for hemorrhoids, performed by a surgeon. No hospital stay.

- No tissue is cut
- Done in one visit, by a surgeon
- Backed by published five-year results

A modern option that sits between repeat banding and surgery.

HOW IT WORKS

Nothing cut, nothing removed.

Thermal energy is applied to the tissue just above the hemorrhoid. The tissue contracts and the hemorrhoid is drawn back into its normal position. Nothing is cut or removed.

1 **Thermal energy** just above the hemorrhoid

2 **No cutting** of tissue

3 **Drawn back** into its normal position

WHY CHOOSE IT

Why patients choose it.

~87%
symptom-free at 5 years

1
in-office visit

Most people are back to their normal routine very soon. We accept commercial insurance and also offer self-pay.

Ready to talk it through?

Request a consult at transformweightloss.com or call the clinic.

FROM CONCEPT TO PRINT

This is a **content and layout concept**, meant to align on the message, tone, and feel. The **final brochure would be produced by a designer**, built to the exact specifications (size, bleed, fold, and color profile) of the print shop the clinic chooses. The photography shown is placeholder for visualization, and the clinic details and clinical claims still need medical and legal sign-off.

A calm, dignified piece patients can pick up and trust.

Plain language, real evidence, no hype. The same voice as everything else in the kit.

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Seattle Clinic Kit · Draft for review · August 2026.

06 · KNOW THE CONDITION

What the front desk should know.

Callers describe symptoms in their own words, mention treatments they have already tried, and ask how this compares. This page covers the condition, the words patients actually use, and the full treatment landscape, so the team can follow a conversation without ever having to diagnose.

Search a symptom, treatment, or term, like banding, prolapse, or gr

THE ONE RULE FOR THIS PAGE

Understanding is not diagnosing. Everything here exists so the team can follow a caller and answer plainly. Deciding what a patient has, what grade it is, or which treatment suits them is the surgeon's job at the consult, every time.

THE BASICS

What a hemorrhoid actually is.

Everyone has hemorrhoidal cushions. They are normal, and they help with continence. The problem starts when they swell, bleed, or slip out of position. That is what people mean when they say they "have hemorrhoids."

Internal

Above the dentate line, inside the anal canal. There are few pain nerves up there, so internal hemorrhoids more often show up as **painless bleeding** or as something bulging out, rather than as pain.

External

Below the dentate line, under the skin around the opening. This area has plenty of pain nerves, so these are the ones that **hurt**, especially if a clot forms (thrombosed).

WHY THIS DISTINCTION MATTERS ON A CALL

A caller saying "it doesn't hurt, there's just blood" and a caller saying "there's a painful lump" may be describing two different things. Do not sort it out on the phone. Note what they said, and let the surgeon examine it.

COMMON SYMPTOMS

What callers describe.

The five things people ring about, and a sense of what each usually means.

Bleeding

Bright red blood on the paper, in the bowl, or on the stool. The single most common reason people call, and usually painless.

"There's blood when I go."

Prolapse

Something bulges out during a bowel movement. It may go back on its own, need pushing back, or stay out. This is what grading measures.

"Something comes out."

Itching or irritation

Ongoing itch, burning, or dampness around the area. Common, and often the symptom people are most embarrassed to name.

"It itches constantly."

Pain

More typical of external hemorrhoids. Sudden severe pain with a firm lump can mean a clot has formed.

"I can't sit down."

Feeling of fullness

A sense that the bowel has not fully emptied, sometimes with mucus or seepage.

"It never feels finished."

"I've tried everything"

Creams, fiber, maybe banding that did not hold. This caller is often the best fit for a consult, and the most frustrated.

"Nothing has worked."

WHEN TO STOP AND ESCALATE

Heavy or continuous bleeding, dizziness or faintness, severe unrelenting pain, or fever. **Do not book a routine consult.** Advise prompt medical care and flag it to the clinical team straight away. The same applies to anyone who mentions a change in bowel habits or unexplained weight loss, since bleeding has causes other than hemorrhoids and only a clinician can tell them apart.

GRADES

How clinicians describe severity.

Internal hemorrhoids are graded I to IV by how far they prolapse. A caller may know their grade from a previous diagnosis. Note it if offered, and leave the judgement to the surgeon.

I

Visible but does not prolapse. May bleed.

II

Prolapses with straining, goes back on its own.

IN THE PUBLISHED STUDY

III

Prolapses and has to be pushed back manually.

IN THE PUBLISHED STUDY

IV

Stays out and cannot be pushed back.

THE SAFE LINE ON GRADES

"That's exactly the kind of thing the surgeon will look at during the consult." **Grade never decides a booking on the phone.** Someone with symptoms who wants treatment and clears the qualifying checks gets offered a consult.

THE TREATMENT LANDSCAPE

Every option, and where ours sits.

Callers have usually already tried something, and often ask how this compares to what their last doctor offered. This is the map. Read it so the conversation makes sense, not so it can be recited.

TREATMENT	WHAT IT IS	TYPICALLY USED FOR	WORTH KNOWIN
START HERE · ALMOST EVERY PATIENT BEGINS WITH THESE			
Diet and lifestyle fiber, fluids, habits	More dietary fiber, more water, and less time and straining on the toilet.	Every grade, as a first step and alongside anything else.	Clinical guidanc that treatment a always starts her whatever comes
Over-the-counter creams, ointments, suppositories, sitz baths	Pharmacy products that calm the symptoms.	Mild or flaring symptoms.	These soothe. Th not aimed at the underlying hemorrhoid, wh why symptoms c return.
IN-OFFICE PROCEDURES · NO HOSPITAL STAY			
Rubber band ligation banding · RBL	A small band is placed at the base so the tissue is cut off from its blood supply and drops away.	Lower grades.	The most comm office treatment Often has to be repeated over se visits.
Sclerotherapy injection	A solution is injected to shrink the hemorrhoid.	Lower grades.	Often chosen wh patient has a ble

TREATMENT	WHAT IT IS	TYPICALLY USED FOR	WORTH KNOWIN
			disorder or takes blood thinners.
Infrared coagulation IRC	Infrared light creates scar tissue that cuts off the supply.	Lower grades.	Quick to perform often needs mor one session.
Hemorrhoidal energy therapy HET	Gentle compression combined with heat.	Lower grades.	A caller who has researched onlir raise this one by
Thermal submucosal hemorrhoidopexy TSH · our procedure OURS	Thermal energy is applied to the tissue just above the hemorrhoid. The tissue contracts and the hemorrhoid is drawn back into its normal position. Nothing is cut or removed. CONFIRM: MECHANISM WORDING	Grades II and III in the published study.	Done by a surge single office visit Published follow five years report patients sympto free.
SURGICAL · OPERATING ROOM			
Excisional hemorrhoidectomy Milligan-Morgan	The hemorrhoid is surgically removed.	Higher grades, external and mixed disease, and cases that have come back.	The long-standir reference standa Usually general anesthesia, with longer and harde recovery.
Stapled hemorrhoidopexy PPH	A circular stapler lifts and fixes the tissue back into position.	Prolapse-dominant cases.	Less post-operat pain than excisic with its own spe risks the surgeor discusses.
Doppler-guided artery ligation HAL-RAR · THD	A Doppler probe locates the feeding artery, which is then stitched closed.	Lower to middle grades.	The closest mod relative to our procedure in int both target the problem withou removing tissue.

READ THIS BEFORE USING THE TABLE ON A CALL

Describe our procedure on its own terms and never rank it against another treatment by name. Comparative claims are off-limits, and this table exists to help the team follow a caller, not to argue with one. Where a caller wants a comparison, the answer is always the same: *"The consult is the best place to compare the options for your situation."* The clinical detail here still needs sign-off. CONFIRM: CLINICAL REVIEW OF THE MATRIX

Where our procedure sits in the landscape

Two broad families exist. One **removes** the hemorrhoid, which is surgery. The other **treats it in place**, which is everything done in an office.

Within the in-office family, our procedure is the one performed by a surgeon in a single visit, with published five-year follow-up behind it. That is why patients and physicians describe it as sitting between repeat banding on one side and an operation on the other. That framing is fair to say. Claiming it is *better* than either is not.

If a caller has already had banding that did not hold, they are describing exactly the situation this procedure was studied in. That is still a consult conversation, not a phone diagnosis.

PATIENT VOCABULARY

What they say, what it means.

People rarely use clinical words for this. Recognising the everyday version keeps the conversation comfortable, and there is no need to correct anyone's language.

WHAT THE CALLER SAYS	WHAT THEY ARE DESCRIBING
"Piles"	Hemorrhoids. Common usage, especially for British and older callers.
"Roids"	Hemorrhoids, informally. Mirror the caller's comfort level rather than their exact word.
"Something's coming out"	Prolapse. Whether it goes back on its own is what grading turns on.

"I have a lump"	Often an external hemorrhoid, possibly thrombosed if it came on suddenly and hurts.
"There's blood when I go"	Rectal bleeding. The most common presenting symptom, and one that always deserves a clinician's eyes.
"I had the bands done"	Rubber band ligation. Ask when, and how many times, and log it.
"Skin tag"	Loose skin that can remain after a hemorrhoid settles. Not the same thing as a hemorrhoid.
"A tear" or "a cut"	Possibly an anal fissure, which is a different condition with different treatment. Note it and let the surgeon sort it out.

KIT TERMS

The few work terms used in this kit.

Not clinical, but they appear on the other pages.

Terms from the rest of the kit

TSH

Thermal submucosal hemorrhoidopexy, the full clinical name of the procedure. On a call, say "the procedure" rather than the acronym.

Consult

The short appointment where the surgeon confirms whether the procedure fits, and answers every clinical question. It is the goal of every conversation.

Qualified lead

A real person who can get to the clinic, can pay through commercial insurance or self-pay, has symptoms, and wants them treated. The checklist is on page 02.

Nurture

Interested but not ready to book. Keep the door open with light follow-up, never pressure.

Disposition

The outcome recorded for a lead: booked, nurture, or passed, plus the reason.

PHI

Protected health information: any health detail tied to an identifiable person. Collect the minimum needed to reach and schedule, and leave the history to the consult.

Enough understanding to follow the conversation.

Never enough to diagnose, and never a reason to skip the consult. When a new word or question keeps coming up on calls, add it here.