

ENOSCOPY CENTER, LLC

AUTHORIZATION FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OUTPATIENT PROCEDURES

(1) I authorize the performance upon _____
Name of Patient
the following procedure Colonoscopy with possible biopsy, possible polypectomy _____

to be performed under the direction of Dr. _____

(2) It has been explained to me that during the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in paragraph (1). I therefore authorize and request that the above named physician, his assistants, or his designees perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to remedying all conditions that require treatment and are not known at the time the operation is commenced.

(3) The nature of my condition, other methods of treatment, and the common risks associated with the procedure have been explained to me to my satisfaction by Dr. _____

(4) I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the service.

(5) I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as the result of the treatments or examination.

(6) For the purpose of advancing medical education I consent to admittance of medical observers to the Endoscopy Suite.

(7) I consent to the photographing or televising of the procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.

(8) I authorize the Suburban Endoscopy Center, LLC to submit insurance claims for the facility fee. I further request these payments to be made to the Suburban Endoscopy Center, LLC.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO THE PROCEDURE THAT THE EXPLANATIONS REFERRED TO THEREIN HAVE BEEN MADE, AND THAT ALL BLANKS REQUIRING INSERTION OR COMPLETION WERE FILLED IN OR STRICKEN BEFORE I SIGNED.

Signature of Patient _____ Date: _____

Responsible Agent Signature: _____ Witness: _____

IT IS UNDERSTOOD THAT IF ANY OF THE FIRST FIVE ITEMS ARE STRICKEN BY THE PATIENT, INFORMED CONSENT IS NOT IN EFFECT AND THE PROCEDURE CANNOT BE PREFORMED.

PHYSICIAN CONFIRMATION OF INFORMED CONSENT

I have explained to the patient (or legally responsible agent _____))
Name

his/her condition, the proposed procedure, other methods of treatment, and the possible common complications.

Date: _____
Physician's signature