EASTSIDE ENDOSCOPY CENTER

PATIENT CONSENT
ESOPHAGOGASTRODUODENOSCOPY (EGD)

I authorize Dr. Karim Shakoor to perform the procedure: **ESOPHAGOGASTRODUODENOSCOPY (EGD), possible biopsy, possible dilation, which has been advised by my physician.**

In this procedure flexible lighted tube is inserted through the mouth to examine the esophagus, stomach, and upper small intestine. Sedation will be provided, and specimens may be obtained by biopsy or cytology. If needed, a narrowing may be stretched, bleeding controlled, or a foreign body removed. If an unsuspected condition is discovered at the time of procedure, authorization is given to perform such treatment as deemed necessary by the doctor and such other persons as are needed to assist him/her. Any tissue removed will be disposed of by the laboratory in accordance with accepted standards.

I understand that potential benefits include better understanding of symptoms/a disease process, ability to obtain tissue or cells for analysis, perform a needed instrumentation or assess prognosis.

I further understand the alternatives include: **Doing Nothing or Upper GI series X-Rays.** I understand that I have the right to refuse the recommended procedure.

Potential risks of this procedure include:

a. Injury to the digestive tract such as bleeding, perforation(tearing) or infection /or hemorrhage that may require immediate surgery and/or hospitalization, and very rarely can result in death.
b. Medication reaction such as drop in blood pressure, diminished breathing effort, irregular heartbeat or allergic reaction.
c. Aggravation of an existing medical condition.

I understand that not every potential risk or complication can be anticipated or included in an informed consent form. _____ (patient initial)

I understand that there are potential risks, benefits and alternatives associated with having my procedure performed in an ambulatory surgical facility. These risks and benefits include but are not limited to the following: Risks—since the endoscopy center is not an acute care center, should I require emergency services, I would be transferred to the hospital. Benefits: This center may provide more convenient care as well as less exposure to infection. Alternative: The procedure may be performed in the hospital.

I understand that it may be necessary to test the patient's blood while in the Surgery Center to protect against possible transmission of blood-borne diseases such as Hepatitis-B or Acquired Deficiency Syndrome (AIDS). If for example, a Surgery Center employee or physician is stuck by a needle or sustains a scalpel injury, I understand and consent that the patient's as well as the employee's or physician's blood will be tested (as appropriate). I further understand that the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with state and federal laws.

I know sedation and/or anesthesia (complete or partial loss of physical sensation) will be needed for the operation or procedure. The risks for sedation include but are not limited to: an unconscious state, drop in blood pressure, depressed breathing and in rare cases can be fatal. I also understand that I will not be able to drive a vehicle, operate any power equipment, or sign any legal documents for 24 hours after the sedation. Patient Initial: _____

Photos or specimens taken during a procedure may be used solely for research or education purposes. Patient identification will not be disclosed. Permission to use this information for the aforementioned purposes may be rescinded at any time at the discretion of the patient.

I understand that my physician may have additional personnel in the Procedure Room to observe or assist. Patient Initial: _____

I understand the information presented in this informed consent form and have the opportunity to ask questions and have them answered. I understand that I should not sign this form if all of my questions have not been answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

I have read and fully understand the information in this form.

_____ _____ _____
Patient Signature Date Time

_____ _____ _____
Witness Signature Date Time

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented to the procedure.

_____ _____ _____
Physician's Signature **Date** **Time**

This patient is unable to confer consent related to _____

Consent is therefore given by a) verbal, b) phone or c) proxy.

_____ _____ _____
Signature of proxy **Relationship to patient** **Date & Time**

_____ _____
Witness Signature **Date & Time**

EASTSIDE ENDOSCOPY CENTER

Consent for Anesthesia

I realize that I have the right to refuse any drugs, treatment of procedure to the extent permitted by law.

The nature and purpose of the anesthetic and anesthesiologic procedures including possible alternative anesthetics and anesthesiologic procedures has been explained to me. I understand that anesthesia involves risks and complications in addition to the risks of the procedure itself. These risks may include adverse drug reactions, brain damage, nerve injury, liver injury or death. Additional risks may include such things as injury to teeth or dental work, damage to vocal cords, respiratory problems, possible awareness, minor pain and discomfort, damage to arteries or veins, or headaches.

1. I also realize that the following additional anesthesia-related risks may occur in connection with the particular procedure(s) proposed to me:

   _____

   _____

   _____

2. I am aware that in administration of anesthesia an intravenous line must be placed in my extremity for the administration of drugs and monitoring. I understand there are risks and complications associated with the placement of these lines which may occur.
3. This information has been explained to me and I understand it. I acknowledge that no guarantee has been given to me concerning the results that may occur.
4. I understand that the anesthetics shall be administered by a Nurse Anesthetist, working under the supervision of a physician.
5. I understand that I have the right to ask the Nurse Anesthetist questions about anesthetic and anesthesiologic procedures at any time. I may revoke this consent in whole or in part by written notification to the Nurse Anesthetist or endoscopy Physician. I do hereby certify that I have read and fully understand the above Consent; the explanations herein referred to were made; all lines or statements requiring insertion or completion were completed; and any paragraphs not applicable were stricken before I signed this consent.

Patient Signature	Admitting physician signature	Date & Time AM PM
If patient is incapable of consenting, signature of the nearest relative or legal guardian, or one legally entitled to consent	Admitting physician signature	Date & Time AM PM

NURSE ANESTHETIST CERTIFICATION: I have discussed the procedures as outlined in this Consent for Anesthesia Form with the patient of the patient's authorized representative and answered all questions. Following our discussion this Form was signed in my presence. It is my opinion that the matters discussed on this date are understood by the involved parties.

Signature of Nurse Anesthetist	Date	Time AM PM

My signature below confirms that I was notified prior to my procedure at the Eastside Endoscopy Center LLC:

1. Rights and Responsibilities
2. Policy on Advanced Directives
3. Privacy Agreement
4. Ownership Disclosure

_____ _____
Patient Signature Date

PRIVACY CONTACT INFORMATION

May we contact you at:
(Check all that apply)

- ☐ Home
  - ☐ Ok to leave message
  - ☐ Ok to leave call back number
- ☐ Work
  - ☐ Ok to leave message
  - ☐ Ok to leave call back number
- ☐ Mail
  - ☐ Home _____
  - ☐ Work _____

_____
(Address)

Do you authorize release of personal health information to anyone other than yourself?

If so, please List:

Name	Relationship to you
_____	_____
_____	_____
_____	_____

I have received my health information rights, and I understand how my personal health information may be used by the Eastside Endoscopy Center, LLC, for matters relating to my case, such as submitting charges.

_____ _____
Signature of patient Date

_____ _____
Witness Date

FINANCIAL INFORMATION

You may receive bills from several different providers for the care rendered to you today. The physician performing the procedure, the Ambulatory Surgery Center (ASC) and the anesthetist. If specimens are obtained during your procedure, you will also receive a bill from the laboratory and the pathologist who interprets the specimen.

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you; however, we are required to collect payment for co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account. If the charges remain unpaid, it may become necessary to turn the account over to a collection agency, in which case, the patient will be responsible for both the outstanding charges as well as the collection agency fees.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare / Medicaid / Other Insurance

I hereby assign benefits to be paid, on my behalf, to the ASC that renders service to me. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third-party payer. I certify that the information provided with regard to insurance coverage is correct.

RELEASE OF INFORMATION

I authorize the ASC to release all or part of my medical records when required for the submission of any insurance claims for payment of the Centers for Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a worker's compensation claim).

I also authorize reports of my evaluation, treatment, and any follow up evaluations to be sent to or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician(s), as well as any other healthcare providers, hospitals, or outpatient facilities that I have or will identify to you.

I permit a copy/fax of this form to serve as an original signature of authorization.

RIGHT TO SITE OF SERVICE & FEE SCHEDULE

A schedule of typical fees for services provided by this facility is available upon my request. These procedures are performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

_____ _____

Patient Signature Date

EASTSIDE ENDOSCOPY CENTER

Anesthesia Sign-Off Note

Discharge criteria Score/ Aldrete Score

Activity: Able to move voluntarily or on command	
Four extremities	**2**
Two extremities	**1**
Zero extremities	**0**
Respiration	
Able to breathe deeply and cough freely	**2**
Dyspnea, shallow or limited breathing	**1**
Apneic	**0**
Circulation	
Blood pressure +/– 20 mm of pre-sedation level	**2**
Blood pressure +/– 20 – 50 mm pre-sedation level	**1**
Blood pressure +/– 50 mm of pre-sedation level	**0**
Consciousness	
Fully awake	**2**
Arousable on calling	**1**
Not responding	**0**
Color	
Normal	**2**
Pale, Dusky, and Blotchy	**1**
Cyanotic	**0**

*A score ≥ 9 is required for discharge.

This patient meets the above anesthesia criteria to be discharged from Eastside Endoscopy, LLC.

Notes/Comment:

_____

_____

_____

_____

Sign-Out Time: _____

Signature/Credentials: _____

Date: _____