AG
Associates in Gastroenterology, P.C.
Endoscopy Centers of Colorado Springs

PRE-PROCEDURE PACKET

Welcome to the Endoscopy Centers of Colorado Springs. We would like to make your procedure as pleasant and safe as possible. Please read through your paperwork carefully in advance of your procedure and call us at (719) 785-3500 (opt.2) if you have questions or concerns.

Before the day of your procedure:

- **Contact your Insurance Company.** It is your responsibility to update your insurance and referral information. Questions concerning your co-pays, deductibles, or coverage, should be directed to your insurance provider.
- **Please READ (but do not sign or date) the Patient Rights/Financial Information, Procedure and Anesthesia Consent forms.** We will have you sign an electronic version of these forms at the Center on the day of your procedure.
- **Review your Preparation Instructions.** Please read through your preparation instructions and call us if you have any questions.

The day of your procedure:

- You should arrive at the Endoscopy Center 1 hour before your scheduled procedure time, and you should plan on being at the Endoscopy Center approximately 2 hours.
- Wear loose fitting, comfortable clothes. Bring socks to keep your feet warm. You will be required to change into a patient gown. Prior to the procedure you will be asked to remove any dentures or eyeglasses. Leave all jewelry and valuables at home.

Things to bring with you to your procedure:

- **Insurance Card**
  Current medical insurance information must be provided to prevent errors in billing and avoid charges that you might otherwise have to pay.
- **Medical History Form**
  Please fill out and bring with you the Patient Information and Medical History forms included in this packet. You will be asked questions about your medical and surgical history, but it is helpful to have this information in written format.
- **Medication List**
  Be sure to fill out the Medication List with all medications, including over-the-counter meds, you are currently taking. List the exact name, dosage, and number of times a day you take each medication. Include all meds—even those stopped for the procedure.
- **Name and Address of your Referring Provider**
  If you would like a copy of your procedure report sent to your referring provider, please bring their information to ensure your paperwork gets to their office.
- **Power of Attorney or Advance Directive Paperwork**
  If you have a Power of Attorney (POA) or Advance Directive, you must bring a copy for our records to ensure your preferences are known. If you are the patient's POA, and the patient is incapacitated, you must accompany the patient to sign the consent form.
- **Emergency Inhaler**
  If you use an emergency inhaler for breathing, please bring it with you.

Points to Remember:

- **Driving is not permitted the day of your procedure** to allow the sedative time to wear off. Please make arrangements for a responsible adult to remain at the Center and accompany you home after your procedure. We request that your driver remain at the center during your exam. However, if this is not possible, we will ask for contact information such as a cell phone number. **You may not take a taxi, non-medical ride service, or bus without a responsible adult to accompany you home**.

- If you need to reschedule or cancel your procedure, please call the office at (719) 635-7321 and speak with the scheduling department.

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INSTRUCTIONS FOR PATIENTS WITH DIABETES

If you have diabetes, you will have to modify your meal plan and your medication routine during the clear liquid and fasting periods of the preparation.

Below are our general instructions for managing diabetes from the day before your procedure until the first meal after the procedure.

We encourage you to contact your primary care physician or the doctor managing your diabetes for more individualized advice regarding your glucose control for the endoscopic procedure.

Please read your instructions carefully before your procedure and call us if you have questions or concerns at (719) 785-3500 (opt.2).

The day before your procedure:

- **FOLLOW YOUR USUAL MEDICATION ROUTINE**: Take your medications as prescribed on your usual schedule.
- **CHECK YOUR BLOOD GLUCOSE LEVEL**: Check your blood sugar frequently. Every 4-6 hours is recommended to make sure your blood sugar is remaining stable. If you have any questions about your diabetes management, please consult with your primary physician.

The day of your procedure:

- **DO NOT TAKE ORAL MEDICATION**: If you take a pill to lower your sugar, do not take it on the morning of your procedure.
- **DO NOT TAKE SHORT-ACTING INSULIN**: If you are taking short-acting or regular insulin (R), do not take it on the morning of your procedure.
- **TAKE ½ OF LONG-ACTING INSULIN**: If you are taking an intermediate, long-acting, or combination insulin, take half of your prescribed dose on the morning of the procedure on your usual schedule.
- **INSULIN PUMP**: If you use an insulin pump, please contact the provider that prescribes this for instructions on how to adjust for the prep you are to take and for fasting the morning of the exam.
- **CHECK YOUR BLOOD GLUCOSE LEVEL**: Please check your blood sugar level before leaving home to come in for your procedure. You may have up to 2 oz. of apple juice or white grape juice up to 2 hours prior to your procedure if your blood sugar reading is low or you are feeling symptomatic of low blood sugar. A nurse will check your blood glucose prior to your procedure.
- **BRING YOUR MEDICATIONS**: Please bring your insulin or other diabetic medications with you to ensure that you can take these medications along with a meal after your procedure.

After your procedure:

- **RETURN TO YOUR NORMAL ROUTINE**: You will resume your medicines after the test when you are eating a regular diet. Do not take any extra dose of medicines to make up for missed dose amounts. Blood sugar readings may not return to your usual numbers for up to 72 hours after the procedure.

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PATIENT INFORMATION SHEET

Name_____**Sex: □ F □ M DOB**_____ **Age**_____**Date** _____

Primary Care Physician: _____**Primary Care Physician's phone #:**_____

Reason I'm having this procedure: _____

PAST MEDICAL AND SURGICAL HISTORY (Circle Yes or No) Do you now or have you ever had:

Medical Condition	Yes	No	Comments	Medical Condition	Yes	No	Comments
Heart Problems	Yes	No		Stomach Problems/Ulcers	Yes	No	
High Blood Pressure	Yes	No		Celiac Disease	Yes	No	
Heart Murmur	Yes	No		Crohn's Disease	Yes	No	
High Cholesterol	Yes	No		Colitis	Yes	No	
Chest Pain/Angina	Yes	No		Jaundice	Yes	No	
Abnormal Heart Rhythm	Yes	No		Hepatitis/Liver Problems	Yes	No	
Pacemaker/Internal Defibrillator	Yes	No		Anemia	Yes	No	
Breathing Problems	Yes	No		Bleeding Disorder	Yes	No	
Asthma	Yes	No		Kidney Problems	Yes	No	
Pneumonia	Yes	No		Thyroid Problems	Yes	No	
Emphysema	Yes	No		Arthritis/Joint Problems	Yes	No	
Pulmonary Embolism	Yes	No		Stroke	Yes	No	
Tuberculosis	Yes	No		Epilepsy/Seizures	Yes	No	
Sleep Apnea	Yes	No		Headaches/Fainting/Dizziness	Yes	No	
Diabetes	Yes	No		Glaucoma	Yes	No	
Swallowing Difficulties	Yes	No		Cancer, Type:	Yes	No	
Gastric Reflux/Heartburn	Yes	No		Blood or Infectious Disease	Yes	No	
Hiatal Hernia	Yes	No		Anxiety/Depression	Yes	No	
Other Medical Conditions (please list):							

Past Surgery	Yes	No	Comments	Past Surgery	Yes	No	Comments
Colon	Yes	No		C-section	Yes	No	
Stomach	Yes	No		Breast	Yes	No	
Heart	Yes	No		Other surgeries:			
Joint Replacement	Yes	No		Other surgeries:			
Gallbladder	Yes	No		Other surgeries:			
Hysterectomy	Yes	No		Other surgeries:			
Appendectomy	Yes	No		Anesthesia Problems	Yes	No	
Prostate	Yes	No		Previous EGD	Yes	No	
Bladder	Yes	No		Previous Colonoscopy	Yes	No	

Social History (Past or Present)	Yes	No	Quit Date	Amount
Tobacco	Yes	No	Quit	
Alcohol	Yes	No	Quit	
Caffeine	Yes	No	Quit	
Recreational Drug Use	Yes	No	Quit	
Do you exercise?	Yes	No	How much?	

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Name:

Family History: Please indicate any **RELATIVES** with the following diseases.

Colon Cancer	Yes	No		Celiac Disease	Yes	No	
Colon/Rectal Polyps	Yes	No		Gallstones	Yes	No	
Crohn's Disease	Yes	No		Hemochromatosis	Yes	No	
Colitis	Yes	No		Heart disease	Yes	No	
Diabetes	Yes	No		High Blood Pressure	Yes	No	
Anesthesia Problems	Yes	No		Liver Disease	Yes	No	

Symptom Review Check (☒) symptoms you currently have or have had in the past

☐ Weight Loss	☐ Cough	☐ Frequent urination	☐ Memory loss
☐ Fever/Chills	☐ Shortness of breath	☐ Incontinence of urine	☐ Depression
☐ Poor vision/double vision	☐ Heart burn	☐ Difficulty urinating	☐ Anxiety
☐ Dry mouth	☐ Nausea / vomiting	☐ Blood in urine	☐ Hair loss
☐ Frequent nosebleeds	☐ Swallowing difficulties	☐ Arthritis/Joint pain	☐ Hot/Cold sensitivity
☐ Hearing loss	☐ Pain with swallowing	☐ Muscle aches	☐ Excessive thirst
☐ Nasal congestion	☐ Abdominal pain	☐ New or chronic rash	☐ Easy bruising
☐ Hoarseness	☐ Diarrhea	☐ Nail changes	☐ Excessive bleeding
☐ Chest pain	☐ Constipation	☐ Headaches	☐ Swollen lymph nodes
☐ Irregular heartbeat	☐ Blood in stool	☐ Seizures	☐ Swelling of ankles/legs

Other:

Other:

Other Physicians Who Are Actively Treating You:	
Physician:	Condition:
Physician:	Condition:
Physician:	Condition:
Physician:	Condition:

My_____**(**family member**),** _____**(**name**) has been treated by this same Gastroenterologist.**

DO NOT WRITE BELOW THIS LINE. PHYSICIAN AREA ONLY

History Reviewed by:

If this form was filled out more than 30 days ago physician will review and update:

Updated_____Physician Signature:_____
Updated_____Physician Signature:_____
Updated Physician Signature:

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MEDICATION AND ALLERGY LIST

Name_____DOB_____ Procedure Date _____

It is important for your physician and anesthesia provider to have a complete list of your medications and allergies. Please help us by taking the time to provide us a list of your allergies and all your medications (Both over-the-counter and prescription), supplements, and pumps/patches as accurately and completely as possible. Thank you.

Active Allergy List

□ No known allergies

Allergy	Reaction	Severity	Comments

Latex Allergy? YES NO Iodine Allergy? YES NO Egg Allergy? YES NO

Active Medication List

□ No present medications/supplements

Medication	Dose	Route	Frequency	Reason	Taken Today?	Date Last Taken
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	
					□ Yes □ No	

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PATIENT RIGHTS AND RESPONSIBILITIES

The Endoscopy Centers of Colorado Springs, LLC and its medical staff have adopted the following statement of patient rights. This list shall include but not be limited to the patient's right to:

1. Be treated with respect, consideration, and dignity. Care will be provided in a safe environment, free from all forms of abuse or harassment. The patient may exercise these rights without regard to sex, cultural, economic, educational or religious background or the source of payment for care.
2. Informed and easily understood information about their health care plan, treatment, health care professionals, and the facility. Patients that speak another language will be provided interpretation services. Patients that have a physical or mental disability can expect reasonable attempts will be made to communicate in a manner primarily used by the patient.
3. Information about any proposed treatment or procedure in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, any alternate courses of treatment or non-treatment and the risks involved in each.
4. Participate in the development and implementation of their plan of care and actively participate in decisions regarding their medical care, except when such participation is contraindicated for medical reasons. To the extent permitted by law, this includes the right to request and/or refuse treatment. Information from their physician about a patient's illness, course of treatment, (including unanticipated outcomes), and prospects for recovery in terms he/she can understand.
5. Refuse to participate in experimental research.
6. Knowledge of the physician performing his/her procedure and the names of healthcare providers who will provide him/her care. The patient has the right to change his/her provider if another qualified provider is available.
7. Information concerning the credentials of health care professionals, and knowledge of the credentialing process for medical staff. This is available to patients upon request.
8. Information regarding physicians' liability insurance coverage. It is the policy of the ASC for all physicians to carry malpractice insurance.
9. Information regarding the services provided at the ASC.
10. Privacy concerning his/her medical care. Health care professionals will conduct confidential case discussions, consultations, examinations and treatments discretely. The patient has the right to be advised of the reason for the presence of any individual involved in his/her healthcare.
11. Confidential treatment and security of all communications, records and individually identifiable health information pertaining to his/her care and his/her visit to the facility. Except when the law requires, patients have the opportunity to approve or refuse the release of their records.
12. Access to information contained in his/her medical record within a reasonable frame of time, (within 48 hours of request, excluding weekends and holidays), to include information regarding diagnosis, evaluation, treatment and prognosis. If it is medically unadvisable to give such information to the patient, a person designated by the patient, or a legally authorized person shall have access to the patient's information.
13. Know the physician performing the procedure may have financial interest or ownership in this ASC. Disclosure of this information will be in writing and furnished in advance of the date of the procedure in a language and manner the patient, the patient's representative or surrogate understands. The exception to this is if the physician finds the need for the procedure to be done on the same day as scheduled, and then should be completed during the registration/ admission process.
14. Examine and receive the fees for service. Upon request and prior to the initiation of care or treatment, the patient may receive an estimate of the facility charges and payment policies.
15. Understandable marketing or advertising methods used by the facility identifying the competence and skill of the organization. These will be clear and unambiguous to patients or potential patients.
16. Appropriate assessment and management of pain or sudden illness, including emergency services if required.
17. Reasonable continuity of care. The facility does not have after hours or overnight care. The medical staff will arrange transfer of any patient to a hospital if after hours or overnight care is required.

18. Information concerning their diagnosis, evaluation, treatment, and prognosis to the degree known. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
19. Know the continuing healthcare requirements and instructions following his/her discharge from the facility. The facility services are not intended for emergency care; therefore all practitioners will direct after hours' care to the closest emergency room.
20. Become informed of his/her rights as a patient when discontinuing care or leaving the facility against his/her physicians advice. The patient may appoint a representative or surrogate to receive this information should he/she so desire.
21. Remain free from seclusion or restraints of any form not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
22. Methods for providing feedback, including complaints/grievances should the patient wish to communicate a concern regarding treatment or care.
23. Information concerning advance directives, including a description of the state health and safety laws, and if requested, official state advance directive forms. Documentation of whether or not the individual has executed an advance directive will be in each patient chart.

ADVANCE DIRECTIVES, LIVING WILL, AND CPR DIRECTIVE:

- You may make out a CPR directive (allows you to refuse resuscitation), advance directive (written instructions concerning your wishes about your medical treatment) or living will (which applies only in cases of terminal illness). If you have advance directives, please bring a copy with you that we may place on your chart.
- In order to comply with the Self-Determination Act (PSDA) and State laws and rules regarding advance directives, we will be asking if you have an advance directive. If you do not, this facility's staff will offer you information on how to make an advance directive.
- Should you suffer a cardiac or respiratory arrest or other life-threatening emergency during or after the procedure, we will attempt resuscitation and transfer you to a higher level of care. Your consent to resuscitation (CPR), medical care, and treatment and transfer to a higher level of care is assumed. The policy of this facility is to not implement any directive to withhold resuscitation on the basis of conscience as permitted by State law. The Center will inform all patients of this policy pre-procedure with their written Notice of Patient Rights given to all patients with their prep instructions. Any person with known advance disease who holds advanced directive wishing no resuscitation will be directed to a facility of their choice that will follow their DNR directive.
- Colorado web site: www.ColoradoAdvanceDirectives.com

MEDICAL DURABLE POWER OF ATTORNEY:

- In cases of an adult without decision-making capacity or a minor, the person having legal responsibilities to make decisions regarding medical care on behalf of the patient shall exercise these rights and responsibilities. Minors capable of participating in treatment decisions shall be involved in these decisions along with the parent(s), guardian(s), or surrogate decision-maker. A medical durable power of attorney can cover more health care decisions than a living will does and is not limited to terminal illness.
- Allows you to name an agent or surrogate who can make decisions for you.

PATIENT RESPONSIBILITIES:

The care a patient receives depends partially on the patient. Therefore, in addition to rights listed above, a patient has certain responsibilities as well.

- The patient has the responsibility to provide accurate and complete health information including present complaints, past illnesses, hospitalizations, any medication taken (including over-the-counter medications and dietary supplements), any allergies or sensitivities, and other matters relating to his or her health.
- The patient is responsible for reporting perceived risks in their care and unexpected changes in their condition to their responsible practitioner.

- The patient is responsible for participating in and following the agreed-upon treatment plan established by his or her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible to provide transportation home and to provide a responsible adult for at home care.
- The patient is responsible for his or her actions, for keeping appointments and for notifying the facility or physician should he or she refuse treatment or decide not to follow his or her physician's orders.
- The patient is responsible for providing his/her healthcare insurance information, and for assuring that the financial obligations of his or her care are fulfilled as promptly as possible.
- The patient is responsible for the consequences if he/she refuses treatment or does not follow his/her physician's orders.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible for being considerate and respectful of the rights of other patients, visitors, and facility personnel.
- The patient is responsible for being respectful of his or her personal property and that of other persons in the facility.

DISCLOSURE OF OWNERSHIP:

- Endoscopy Centers of Colorado Springs is an AAAHC accredited freestanding ambulatory surgical center partially owned by some of the Physicians of Associates in Gastroenterology. The following physicians have an ownership interest in this facility: Drs. Lunt, Garza, Kavanaugh, Baker, Swendsen, O'Shea, Drew, Arsene, Burkholz, and Yanchak. These procedures are performed at hospitals and other outpatient facilities in this community. You have the right to choose where to receive services, including a facility where your physician does or does not have an ownership interest.

HOW TO FILE A GRIEVANCE/COMPLAINT:

- If you have a concern, problem, or complaint related to any aspect of the provision of your care, speak to your doctor, nurse, or other staff member. Or you may contact the Endoscopy Center of Colorado Springs Center Director:
  - Susie Gray, RN (Ph. 719-785-3503) 2940 N. Circle Dr. Colo. Springs, CO 80909
- If facility staff have not resolved the problem, you may contact the Colorado State Department of Health by phone or mail or online.
  - Phone: 1-800-886-7689 (ttd line for hearing impaired: 303-691-7700)
  - Mail: Colorado State Department of Health and Environment 4300 Cherry Creek Drive South Denver, Colorado 80246-1530
  - Online: www.cdphe.state.co.us

- You may contact the appropriate professional oversight board at the Department of Regulatory Agencies (DORA) by phone or mail or online.
  - Phone: 1-800-886-7675
  - Mail: Colorado Department of Regulatory Agency, 1560 Broadway suite 1300, Denver, CO 80202
  - Online: www.dora.colorado.gov\professions

- You may contact the Medicare Ombudsman to file a complaint on line at http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

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FINANCIAL INFORMATION

INSURANCE INFORMATION

- Endoscopy procedures are surgical/outpatient procedures and will be processed as such by your insurance company. Your insurance plan will dictate the amount of out-of-pocket expenses. (co-pay—which is higher for ASC than for an office visit, individual and family deductible amounts). We **highly recommend** that you to call your insurance carrier to determine your benefits for the procedure that has been scheduled for you. There may be a difference in coverage for screening versus diagnostic procedures.
- As a courtesy to our patients, we will do the pre-certification required by your insurance provider. In order to do this, we **MUST HAVE A COPY OF YOUR INSURANCE CARD(s)** at least 14 days before the procedure. We will need primary, secondary, (and tertiary) insurance information as all may require pre-certification. It is your responsibility to provide the needed insurance information to our billing department. Failure to provide insurance information or to report updated insurance information prior to the procedure may result in you being responsible for the full balance due.

FINANCIAL AGREEMENT

- If you have insurance, we will help you receive maximum benefits by filing for you. Your insurance benefits will determine the amount of charges that will be billed to you. Copay and deductible will be collected on date of your procedure. Any remaining balance, after insurance has paid, will be billed to you.

ASSIGNMENT OF INSURANCE BENEFITS

- I hereby assign benefits to be paid, on my behalf, to the Ambulatory Surgery Center (Endoscopy Centers of Colorado Springs, LLC), the anesthesia company (Epix Anesthsia of Colorado Springs, LLC), and the Physician 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 the information given with regard to insurance coverage is correct.

RELEASE OF INFORMATION

- I authorize the Endoscopy Centers of Colorado Springs to release all or part of my medical records when required for the submission of any insurance claims for payment to the Centers for Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a workers compensation claim).
- I also authorize reports of my evaluation, treatments, 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.

PROCEDURE FEES

- You will receive bills from several different providers for the care rendered to you today: The physician performing the procedure (Associates in Gastroenterology), the Ambulatory Surgery Center (Endoscopy Centers of Colorado Springs, LLC), Anesthesia services (Epix Anesthesia of Colorado Springs, LLC) and the pathology laboratory and pathologist if specimens are obtained during your procedure.
- If you fail to cancel or reschedule within 48 hours of your scheduled procedure, you may be billed $100.00 for that missed appointment.

AMBULANCE TRANSFER

- If there is a medical condition requiring transfer to the hospital via ambulance, you will be responsible for any cost that your insurance does not cover for the ambulance and hospital charges.

CUSTOMER SERVICE

- If you need to discuss your account and/or set up financial arrangements, please contact our billing department, 719-635-7321. We accept cash or credit cards (Visa, MasterCard or Discover) as payment options.

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EPIX ANESTHESIA FINANCIAL INFORMATION

Dear Patient:

Thank you for allowing Epix Anesthesia of Colorado Springs, LLC to provide the highest level of comprehensive anesthesia services for you. This letter is intended to inform you of our billing practices for the services you will receive or have received. There are multiple billing components, such as the professional services of the surgeon, the professional services of the anesthesia provider(s), the professional services of the pathologist, drugs, supplies and the use of the facilities services and equipment.

As a courtesy, we will bill your primary and/or secondary insurance company for your anesthesia services and make every effort to get our charges paid. If your insurance company, however, deems the anesthesia charge(s) or the services of the anesthesia provider(s) not medically necessary or non-covered according to their policies, you will be billed at our current self-pay rate.

- For all in network carriers we will receive payment with an Explanation of Benefits (EOB), which will explain any co-payments or deductibles owed by you in accordance with your insurance carrier. You will be responsible for paying the co-pays and deductibles if required by your insurance carrier.

- For all out-of-network claims, we are unable to determine the payment your carrier will make and therefore unable to accurately quote the portion of the payment for which you will be responsible. Epix Anesthesia will make every effort to collect all the payments directly from your insurance company. As soon as the EOB is received, we will be able to make that determination and will invoice you the amount you owe according to the EOB. The payment and EOB for our services may also be sent to you. In this case, please send to us at the address below (a) the EOB and (b)(i) the endorsed insurance check, along with a personal check in the amount for which the EOB states you are responsible or (ii) a personal check in the total amount.

- Patients with no insurance coverage will be billed at the current self-pay rate. If you wish to pay for services and not submit a claim to your insurance carrier, please contact our office to discuss possible debt that may be incurred.

- If you are deemed indigent please send to the address below a copy of the letter from your State authority stating so and any amounts owed by you under the EOB will be assessed and adjusted if appropriate.

If you have any questions concerning your anesthesia bill for the procedure(s) you are having or have had, please contact our billing office at:

719-635-7321 Opt 4

Please mail payments, Explanation of Benefits, correspondence, etc. to:

Associates in Gastroenterology
2940 N. Circle Drive
Colorado Springs, CO 80909

Associates in Gastroenterology, P.C.
Endoscopy Centers of Colorado Springs

ANESTHESIA CONSENT FORM

I will need anesthesia services for my upcoming surgical procedure(s). I understand that receiving anesthesia for any procedure involves risks as well as benefits, and that no promises or guarantees can be made concerning the results of anesthetic medications given to me during my procedure. Even minor elective surgery may carry with it major unforeseen anesthetic risks.

Although rare, unexpected severe complications with anesthesia can occur. In addition, risks of all anesthetics may include, but are not limited to, nausea, vomiting, infection, bleeding, drug reactions, blood clots, damage to veins, arteries or nerves, stroke, brain damage, heart attack or death.

The following anesthetic technique(s) have been selected for my procedure. In addition to those mentioned above, risks for the selected types of anesthesia include the following:

_____General/Deep Sedation Anesthesia:
_____Moderate/Conscious Sedation:
Risks include sore throat, hoarseness, injury to teeth, mouth or airway, corneal abrasion (scratch of the eye); aspiration, pneumonia, awareness under anesthesia and muscle aches. Any serious reactions or medical complications may require transfer to the hospital for further treatment.

I understand that during my surgery my physical condition could change, and my anesthetic may be changed to ensure comfort or my safety. Any necessary changes in my anesthetic will be made with my safety as the first concern.

I have had the opportunity to ask questions and to discuss the anesthetic plan, and I understand the information provided. I understand that I may withdraw this consent at any time before the anesthetic is given. I hereby consent to the anesthesia service(s) as indicated above.

TO BE ELECTRONICALLY SIGNED DAY OF PROCEDURE

_____

Patient/Responsible Party (state relationship) Date Time

Anesthetist Declaration: I have explained the anesthesia risks, alternatives and benefits to the patient and have answered all the patient's questions. To the best of my knowledge, I believe the patient understands and has voluntarily consented.

TO BE ELECTRONICALLY SIGNED DAY OF PROCEDURE

_____

Anesthetist's Signature Date Time