

New York GI Center, LLC
Informed Anesthesia Consent

Patient Sticker here

Permission for administration of anesthesia: I hereby request and authorize _____, MD and/or _____ MD/Do/CRNA, (collectively, my "anesthesiologist"), who are reasonably anticipated to be actively involved in the administration of anesthesia, to administer such anesthesia and perform such anesthesia procedures, as may be necessary and as described below. At New York GI Center, the anesthesia technique used for the endoscopy is Monitored Anesthesia Care. This technique includes injections into the intravenous line producing semiconscious state, with spontaneous breathing, and oxygen supplement by nasal prongs or face mask. Amnesia for the procedure is usual, with minimal experienced pain.

Procedure, Risk, Benefits and Alternatives: My Anesthesiologist has explained: (a) the nature and purpose of the anesthesia: (b) alternative forms of anesthesia as well as relevant risks and benefits of such alternative anesthesia: (c) clinical out come if I do not elect to have the proposed anesthesia: (d) the potential benefits and possible risks, side effects and complications associated with the anesthesia: and (e) the likelihood of achieving care, treatment and service goals. Notwithstanding, I authorize administration of the anesthesia noted above and the use of other anesthetic techniques and procedures as may be considered necessary or advisable by my Anesthesiologist during the procedure (s) to which I have consented, including additional or modified procedures or anesthetics that may become necessary.

No Guarantees: I acknowledge that no guarantees or assurances have been made to me concerning the administration of anesthesia or performance of anesthesia procedures.

Release of Medical Information: I authorize the NYGI Center to release my personal health information: (a) to any requesting healthcare provider for my treatment or for that providers payment or health care operations purposes; (b) to any person or entity that may be responsible for billing and/or collection of claims for medical services or products provided by the center; (c) to any person or entity which is or may be liable for all or part of the centers charges, including, but not limited to, insurance companies, HMO's or third party payers; (d) to any governmental agency or other organization responsible for oversight of the center or of any third party payer; or (e) for the centers normal healthcare operations. I acknowledge that I have been provided with a copy of the centers privacy notice.

Assignment of Benefits/Signature on File: I hereby assign, transfer and set over to the center all monies and /or benefits to which I may be entitled from government agencies, including Medicare and Medicaid programs, Medigap, insurance carriers, HMO's or others who are financially liable for my medical care to cover the cost of my care and treatment. I request that the payment of authorized Medicare. Medicaid/Medigap benefits be made on my behalf to the center for any medical services furnished to me by the center, this authorization applies to all occasions of service unless it is revoked.

Payment Agreement: I agree to pay the center for all anesthesia services for which I am financially responsible including, without limitation, those copayments and deductibles that are not covered by my insurance or health benefit plan. If any portion of the anesthesia fee is not covered by insurance, I will pay the full fee upon receipt of a bill. In the event I fail to pay my bill, I agree to pay, in addition to the amount of the bill, any reasonable attorney's fee center incurs in collection the bill.

Understanding of this Form: I confirm that I have read and fully understand this form, and that all the blank spaces have been completed or crossed off prior to my signing. I have been given an opportunity to ask questions and all of my questions have been answered fully and to my satisfaction.

Patient signature: _____ Date: _____

Witness Signature: _____ Date: _____

Provider Certification

I hereby certify that I have explained the nature, purpose, benefits, risks of and alternatives to the proposed anesthesia associated with the procedure to be, have offered to answer any questions and have answered such questions. I believe that the patient understand what I have explained and answered. I have reviewed the above consent form and hereby confirm the accuracy of the document including the description of the administration of anesthesia.

Provider signature: _____, MD Date: _____ Time: _____