Salinas Endoscopy Center
A Covenant Surgical Partner

John R. Carlson, M.D., F.A.C.P.
Lillian Choi, M.D.
Prathibha Chandrasekaran, M.D.
Ronald Waloff, M.D.
Diplomates of the American Board of Gastroenterology

_____ _____
Patient Name Medical Record Number

This information packet is very important. Please review it before your procedure.

Your procedure is with Dr. _____ on _____

For an _____ **Upper Endoscopy**

Instructions: You need to fast the previous night beginning at midnight. You will need a driver to pick you up afterward. Do not use perfumes or lotions with fragrances.

_____ **Colonoscopy**

Instructions: Please stop by our office at least three (3) days prior to your procedure to pick up a prescription and instructions for the prep kit. Prep kits are available at our office or your preferred pharmacy. We charge $20. You will need a driver to pick you up after your procedure. Do not use perfumes or lotions with fragrances.

You need to arrive at 1081 Los Palos Drive at _____.

Please complete ALL the enclosed forms prior to your appointment and bring them with you when you arrive. Bring a list of all medications you are taking. Continue to take all medications as normal **except medicine for diabetes** (insulin or oral hypoglycemics). You may drink a small cup of water on the morning of your procedure (less than 6oz.).

Our financial policy is enclosed for your review. If you have any questions, we are available to answer them at (831) 771-1458. We do accept Medicare Part B assignment. As a courtesy we will bill up to two insurances for you for all services performed by our physicians in our facility. **Please bring your current insurance information with you.** Your co-insurance, deductible, and/or co-pay will all be collected on the day of your procedure. **Please call us if you cannot make your appointment, our no-show policy may subject you to a $150 fee.**

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ABOUT YOUR DOCTOR

John Carlson, M.D.

Dr. John Carlson was raised in Southern California. He attended the University of California, Berkeley, where he played collegiate water polo and majored in microbiology. He attended medical school at the University of California, Los Angeles, graduating in 1978, and subsequently completed his Internal Medicine internship, also at UCLA, in 1981. He completed his fellowship in Gastroenterology at UCSF in 1985. After moving to Salinas in 1985, Dr. Carlson chaired the medical department at SVMH from 1996 to 1998, and again from 2014 to 2016.

Dr. Carlson lives in Salinas with his wife and enjoys visiting his children in the Bay Area on weekends.

Prathibha Chandrasekaran, M.D.

Dr. Chandrasekaran completed her medical training at Bangalore University in her native India. She completed her fellowship and residency at the State University of New York. She is Board Eligible in Internal Medicine and Gastroenterology.

Dr. Chandra, as she likes to be called, lives in Gilroy and enjoys traveling in her free time.

Lillian Choi, M.D.

Dr. Choi is a native of the Bay Area, growing up in Castro Valley, Calif. She attended UC Davis as an undergraduate and went to University of Colorado for medical school. Thereafter, she completed her residency and internship at UC Irvine. Lastly, she completed a specialty fellowship in gastroenterology at the Mayo Clinic.

Dr. Choi lives in Salinas and enjoys spending time with her extended family throughout the Bay Area.

Ronald Waloff, M.D.

Dr. Waloff is a native of Pennsylvania. He received his bachelor's degree from Muhlenberg College. He then graduated with honors from Temple University School of Medicine and subsequently completed his internship and residency at Temple University Hospital, where he was Chief Resident. He completed his fellowship in Gastroenterology at Yale University.

Dr. Waloff lives in Santa Cruz and enjoys being a grandfather.

CONFIDENTIAL PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

SSN#: _____-_____-_____ SEX: M F MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PH#: _____ OTHER PH#: _____ EMAIL ADDRESS: _____

RACE: CAUCASIAN
HISPANIC
AFRICAN AMERICAN
OTHER: _____

ETHNICITY: HISPANIC or LATINO
NON HISPANIC or LATINO
OTHER: _____

LANGUAGE SPOKEN: _____

EMPLOYER: _____ OCCUPATION: _____
REF/PRIMARY CARE PHYSICIAN: _____ TELEPHONE#: _____

SPOUSE/PARENT NAME: _____

DOB: _____ SSN#: _____ OTHER PHONE: _____

EMERGENCY CONTACT: _____

PHONE #: _____ RELATIONSHIP: _____

PREFERRED PHARMACY: _____ PHONE#: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

SUBSCRIBER and DOB: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____

SUBSCRIBER and DOB: _____ RELATIONSHIP TO PATIENT: _____

IF LESS THAN 18 YEARS OF AGE:

FATHER'S NAME: _____ PHONE#: _____

MOTHER'S NAME: _____ PHONE#: _____

I HAVE READ THE FINANCIAL POLICY AND AGREE WITH THE TERMS SET FORTH IN THAT POLICY. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY SALINAS ENDOSCOPY CENTER AND AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO SALINAS ENDOSCOPY CENTER, SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. A PHOTOCOPY OF THIS ASSIGNMENT IS CONSIDERED VALID AS AN ORIGINAL. I AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT. I AUTHORIZE SALINAS ENDOSCOPY CENTER TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.

SIGNED: _____ DATE: _____

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PRE-PROCEDURE HISTORY

Name: _____ Appointment Date/Time: _____

Date of Birth: _____ Physician: _____ Procedure: _____

Height: _____ Weight: _____ Primary Doctor: _____

Do you have:

Recent weight loss?	YES	NO	Diarrhea?	YES	NO	Difficulty swallowing?	YES	NO
Abdominal pain?	YES	NO	Constipation?	YES	NO	Reflux symptoms?	YES	NO
Vomiting?	YES	NO	Rectal bleeding?	YES	NO	Barrett's Esophagus?	YES	NO
Anemia	YES	NO	Divertcular disease?	YES	NO	Gastric Ulcer?	YES	NO
Blood in stool?								

History of Colon Cancer?	YES	NO
History of Gastric cancer?	YES	NO
History of Esophageal cancer?	YES	NO
History of polyps?	YES	NO

Do you have a family history of:

Stomach cancer?	YES	NO	Who? _____	Esophagus cancer?	YES	NO	Who? _____
Colon cancer?	YES	NO	Who? _____	Colon polyps?	YES	NO	Who? _____
Ulcerative colitis?	YES	NO	Who? _____	Crohn's disease?	YES	NO	Who? _____

Have you had:

Previous upper endoscopy/colonoscopy?	YES	NO	If yes, when? _____
Abdominal/Pelvic/Stomach surgery?	YES	NO	If yes, when? _____
Other Surgeries?	YES	NO	If yes, what? _____

Do you have other medical problems:

Heart Disease?	YES	NO	Artificial Valve?	YES	NO
Pacemaker?	YES	NO	Kidney Disease?	YES	NO
Hypertension?	YES	NO	Lung Disease?	YES	NO
Seizure?	YES	NO	Sleep Apnea?	YES	NO
Glaucoma?	YES	NO	High Cholesterol?	YES	NO
Diabetes?	YES	NO			

Do you take any blood thinners, such as:

Coumadin?	YES	NO	Plavix?	YES	NO	Ticlid?	YES	NO
Aspirin?	YES	NO	Pradaxa?	YES	NO	Clopidogrel?	YES	NO
Eliquis?	YES	NO	Xarelto?	YES	NO			

**If yes, these medications need to be stopped 3-5 days prior to the procedure. If a large polyp were to be removed, the medication would need to be stopped an additional 3-5 days. If there is a problem, please discuss this with your prescribing doctor.*

DRUG ALLERGIES: _____

_____ _____
Patient Signature Date

INTERNAL USE ONLY: CRNA _____

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INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

Explanation of Procedure

Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures.

You will receive conscious sedation for the procedure. At the time of your examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of the tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may be removed.

Principal Risks and Complications of Gastrointestinal Endoscopy

Gastrointestinal endoscopy is generally a low risk procedure. The risk of a complication occurring is less than one per thousand. Compared to the national statistics, Salinas Endoscopy Center procedure statistics showed 0.01% incident rate of serious complications, which is 1 complication per 10,000 cases. However, all of the below complications are possible. Your physician will discuss their frequency with you, if you desire, with particular reference to your own indication for the procedure. You must ask your physician if you have any unanswered questions about your test.

1. PERFORATION: Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs surgery to close the leak and/or drain the region is usually required.
2. BLEEDING: Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation, may require transfusion or possibly a surgical operation.
3. MEDICATION PHLEBITIS: Medications used for sedations may irritate the vein in which they are injected. This causes a red, painful swelling of the vein and surrounding tissue. The area could become infected. Discomfort in the area may persist for several weeks to several months.
4. OTHER RISKS: Include drug reactions, over sedation and complications from other diseases you may already have. Instrument failure and death are extremely rare, but remain remote possibilities. **You must inform your physician of all your allergic tendencies and medical problems.**

Alternatives to Gastrointestinal Endoscopy

Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100% accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or a mis-diagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, X-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you

Brief Description of Endoscopic Procedures

1. ESOPHAGOGASTRODUODENOSCOPY (EGD): Examination of the esophagus, stomach, and duodenum with a small endoscope. If active bleeding is found, coagulation by heat may be performed.
2. ESOPHAGEAL DILATATION: Dilating tubes or balloons are used to stretch narrow areas of the esophagus.
3. ENDOSCOPIC INJECTION SCLEROTHERAPY (EIS): Injection of a chemical into varices (dilated varicose veins of the esophagus) to sclerose/harden the vein to prevent further bleeding. Injection is done with small needle probe through the endoscope.
4. FLEXIBLE SIGMOIDOSCOPY: Examination of the anus, rectum and left side of the colon, usually to a depth of 60 cm.
5. COLONOSCOPY: Complete examination of the colon. Older patients and those with extensive diverticulosis are more prone to complication. Removal of small growths called polyps, is performed if necessary, by the use of a wire loop and electric current (polypectomy).

I certify that I received, read and understand the information on "SEC Notice of Privacy Practices." I consent the taking and publication of any photographs made during my procedure for use in the advancement of medical education. I certify that I understand the information regarding gastrointestinal endoscopy. I have been fully informed of the risks and possible complication of my procedure. I hereby authorize and permit:

□ John R. Carlson, M.D., F.A.C.P. □ Prathibha Chandrasekaran, M.D.
□ Lillian Choi, M.D. □ Ron Waloff, M.D.

And whomever they may designate as assistant to perform upon me the following:

□ Upper Endoscopy □ Colonoscopy □ Flex Sig □ Dilation
□ EIS □ Polypectomy □ Others _____

If any unforeseen condition arises during this procedure calling for (in the physician's judgement) additional procedures, treatments or operations, I authorize him to do whatever he deems advisable. 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 concerning the result of this procedure. I am aware that in the event of a life-threatening emergency, the Center will perform any necessary emergency procedures and transfer me to an acute care facility.

_____
Signed (by patient or legally authorized person)

_____
Witness

I have discussed the risks, benefits and alternatives of this procedure with this patient.

_____
Physician's Signature **Date**

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BILLING INFORMATION

You will receive several separate charges for your procedure, and we want to make sure you understand what you, and your insurance, are paying for your visit. All fees for services at Salinas Endoscopy Center are in-network. Most patients will receive four or five charges for their visit:

1. The SEC facility
2. Your gastroenterologist
3. Your anesthesiologist
4. Pathology laboratory (if necessary)
5. The pathologist who reads your specimens (if necessary)

SALINAS ENDOSCOPY CENTER	SEC is an accredited facility that provides an outpatient location for your procedure, much like a small hospital. An estimated price will be calculated for your SEC fee based on your insurance benefits. **If there is a patient pay component, this will be collected the day of your procedure.**
ANESTHESIA	Nearly all patients benefit from being sedated during their procedure. Some patients can tolerate the procedure with only mild sedation ("conscious sedation") wherein you are awake but desensitized. If you prefer only mild sedation, please discuss that with your gastroenterologist. **If you are given deep sedation for your procedure, your anesthesia team will bill you separately.** Our current anesthesia provider is *Anda Anesthesia*.
PATHOLOGY	Frequently, your physician will notice a polyp (a small growth) in your digestive system and remove it for testing during your procedure. By examining the tissue of the polyp under a microscope, a pathologist will be able to tell your doctor if the polyp needs further care. Before the pathologist can examine the specimen, it is sent out to a laboratory for processing and placed in very small slices on multiple slides. **The pathologist is a separate physician from your gastroenterologist and both the pathologist and the laboratory will bill separately for their services**. We currently work with *Covenant Pathology Laboratory*, *Salinas Pathology Services Medical Group* and *Salinas Valley Urology Pathology Lab*, but sometimes physicians request other providers or labs.

NO SHOW POLICY: A **$150.00 fee** will be charged to your account if you miss your procedure without cancelling the appointment within 48 hours in advance of your scheduled procedure time. Quite a bit of preparation goes into your procedure, so if you are going to miss your appointment, please call us!

Please be sure that you have given the scheduler your current, correct insurance information so we can process your claim as quickly as possible. If we don't hear from your insurance carrier within 45 days of this visit, we will bill you directly. We are always available to answer questions at (831) 771-1458.

OUR FINANCIAL POLICY

PATIENT (please print): _____ OFFICE USE ONLY: _____

Thank you for choosing us for your health care needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to treatment.

All patients must complete our *information* and *insurance* form before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR NON-INSURED PATIENTS
- WE ACCEPT CASH, CHECK, ALL MAJOR CREDIT CARDS AND CARE CREDIT.
    - A $10.00 fee is charged on checks returned from the bank for non-sufficient funds.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.
- ALL CO-INSURANCE/CO-PAYS ARE DUE AT THE TIME OF SERVICE

Regarding Insurance

We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. The charge is your responsibility whether your insurance company pays or not. Please be aware that some or all of the services provided may be non-covered services. These services may not be considered reasonable and necessary under the Medicare Program or other medical insurance. We will bill any secondary insurance plan for you. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Medicare Patients

All our physicians accept Medicare's assignment. Medicare has a $185.00 yearly deductible which you may be required to pay if the amount has not been satisfied. At the time of each visit, please be prepared to pay the 20% co-insurance amount.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We Do Not Treat Minor Patients At Our Facility

Thank you for acknowledging our Financial Policy. Please let us know if you have any questions or concerns. Our billing staff can be reached at 831-771-1456, Monday through Friday between 8:00 am and 5:00 p.m.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date_____
Signature of Patient or Responsible Party

X_____ Date_____
Signature of Co-Responsible Party

FINANCIAL INTEREST DISCLOSURE

The Federal Trade Commission (FTC) has released a new rule to protect consumers from IDENTITY THEFT, which is now becoming known as "The Red Flag Rule." The new rule now requires any corporation, which extends credit to implement a written identity theft prevention program. Under the FTC's guidelines, physicians who regularly bill their patients for service rendered (including co-payments, co-insurances, and deductibles) are considered creditors and therefore must comply with the *Red Flag Rules.*

As a result, Salinas Endoscopy center will now require the following information from all patients to ensure the identity of the person been seen:

1) Driver's License or State issued photo identification.
2) Proof of insurance.
3) If your current address does not show on the photo ID or Driver's License, please bring a utility bill with your current address.

Once we have validated that the patient being seen matches the information provided, we will store this proof in the medical records by taking a photocopy of the identification. This eliminates the need to ask for this information in the future unless there was a change from the information provided.

We regret any inconveniences this may cause. We do ask that you remember that just like many other institutions, we must abide by federal law to keep your information protected. As a result, we have very rigid policies and procedures to insure that your records remain confidential and well safeguarded.

If you feel you are a victim of Medicare Fraud, please refer to the following information to report your claim:

Phone: 1-800-HHS-TIPS (800-447-8477)
Email: HHSTips@oig.hhs.gov

Fax: 1-800-223-8164 (no more than 10 pages)
Mail: Office of the Inspector General
HHS TIPS Hotline
P.O. Box 23489
Washington, DC 20026

The referenced below are among those that have a financial interest in Salinas Endoscopy Center:

John R. Carlson, M.D. Prathibha Chandrasekaran, M.D.

As such, it is necessary that we disclose the following information to you:

1) You have the right to use a healthcare facility other than Salinas Endoscopy Center.
2) You will not be treated differently by your physician if you choose a healthcare facility other than Salinas Endoscopy Center.

If you have any questions concerning this notice, please feel free to ask for additional information from your physician or any representative at Salinas Endoscopy Center.

If you are uncomfortable with your physician's relationship with Salinas Endoscopy Center, and prefer to have your surgery performed elsewhere, we will be happy to honor your request. Please do not hesitate to tell us if you wish to have your surgery performed at a healthcare facility other than Salinas Endoscopy Center.

PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVES
OR MEDICAL POWERS OF ATTORNEY

All patients have the right to participate in their own health care decisions and to make advance directives or to execute powers of attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The Surgery Center respects and upholds those rights.

The majority of procedures performed at the Surgery Center are considered to be of minimal risk. Of course, no surgery is without risk. You and your surgeon will have discussed the specifics of your procedure and the risks associated with your procedure, the expected recovery and the care after your surgery.

It is the policy of the Surgery Center, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at the Surgery Center, the personnel at the Surgery Center will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

If you do NOT agree to this policy, the Surgery Center will be pleased to assist you to reschedule the procedure.

Please check the appropriate box in answer to this question:
Have you executed an advance health care directive, a living will, a power of attorney that authorizes someone to make health care decisions for you?

- ☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney
- ☐ No, I do not have an Advance Directive, Living Will, or Health Care Power of Attorney
- ☐ I would like to have information on Advance Directives. The Surgery Center will provide you with applicable state forms upon request.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have asked for information of Advance Directives, I acknowledge receipt of that information.

_____	_____	_____
Patient Signature	Patient Name (print)	Date

If consent signed by other than the Patient:

_____	_____	_____
Signature	Name (print)	Date

Relationship: ☐ Guardian (court appointed) ☐ Attorney-in-fact ☐ Healthcare Surrogate

PATIENT RIGHTS INCLUDE THE RIGHT TO:

- Be informed about Patient Rights before the surgical procedure begins. The patient may appoint a representative to receive this information.
- Exercise Patient Rights without regard to age, race, gender, national origin, religion, culture, disability, economic status, or source of payment for care.
- Considerate, respectful, and dignified care, provided in a safe environment, free from all forms of abuse, neglect, harassment, or reprisal.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Assessment and management of pain.
- Know the name of the physician with primary responsibility for coordinating the patient's care, and the names and professional relationships of other physicians and healthcare providers who will provide care.
- Change providers if other qualified providers are available.
- Know whether physicians hold financial interest in the surgery center.
- Know whether the physician(s) providing care does not carry malpractice coverage.
- Receive sufficient information about proposed treatment(s) and procedure(s) to give informed consent for treatment(s) or refuse treatment(s) and procedures. Excluding emergency situations, information includes: a description of the treatment(s) and procedure(s), the clinically significant associated risks, alternate courses of treatment or non-treatment, the risks associated with each, the name of the person who will provide treatment(s) and/or perform the procedure(s).
- Participate in the development and implementation of the clinical plan of care and actively participate in decisions regarding clinical care. As permitted by law, this includes the right to request and/or refuse treatments and procedures.
- Know the surgery center's policy and state regulations about Advance Directives and request Advance Directive forms in keeping with State regulatory agency requirements.

- Privacy about clinical care, treatment(s) and procedure(s). Case discussion, consultation, examination, and treatment are confidential. Patients have the right to know the reason for the presence and authorize the presence of all individuals participating in or delivering care.

- Confidential treatment of all communications and records pertaining to care at the surgery center. The patient gives written permission to release clinical information to those not directly providing care.

- Receive information as best understood by the patient. Communication with the patient is effective and provided to facilitate the patient's understanding. Written information is appropriate to the age, understanding, and language of the patient. Communications are specific to the patient's vision, speech, hearing, and cognitive status.

- Access clinical record information within a reasonable time.

- Know the surgery center's grievance process, should there be concern regarding care received. Information about the grievance process includes: surgery center contact information, regulatory agency contact information, written notice of the grievance determination or outcome that contains steps taken to investigate the grievance, the results of the findings, and investigation completion date.

- Know surgery center contact information, the State or Federal agency to whom complaints can be reported, and contact information for the Office of the Medicare Beneficiary Ombudsman.

- Know whether surgery center physicians propose or perform experiments, research, clinical trials, or medical education affecting or involving care or treatment. The patient has the right to refuse participation or discontinue participation without compromising access to care, treatment, or services.

- Full support and respect of all patient rights if the patient participates in research projects. This includes the patient's right to grant informed consent as related to the research project. Information given to participants is recorded in the clinical record or research file.

- Receive instructions from the physician(s) or delegate about care after discharge from the surgery center.

- Examine and receive an explanation of charges and costs, regardless of payment source.

- Have all Patient Rights apply to the person delegated legal responsibility to make clinical care decisions on behalf of the patient.

PATIENT RESPONSIBILITIES INCLUDE THE RESPONSIBILITY TO:

- Provide accurate and complete information concerning current and past states of health, present complaints, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities, and any other pertinent health information.
- Understand and/or ask questions about care and services delivered, and about instructions following care and treatment.
- Follow the treatment plan and care instructions, or accept accountability if the treatment plan and care instructions are not followed.
- Keep appointments or notify the surgery center if unable to keep an appointment.
- Leave valuables with a family member/representative.
- Be accompanied at discharge by a responsible adult.
- Inform the surgery center staff of a living will, medical power of attorney, or other directive that could affect care.
- Show respect for other patients and surgery center staff.
- Tell us if there is a problem with care.

ANDA
ANESTHESIA SERVICES

CONSENT FOR ANESTHESIA SERVICES

I, _____, am seeking to receive anesthesia during my pending procedure/operation/treatment. I want to have anesthesia in order to lessen the pain I would otherwise experience. I understand that regardless of the type of anesthesia used there are a number of common foreseeable risks and consequences which may occur. The following are some but not all of the common foreseeable risks and consequences which I have been told can occur; sore throat and hoarseness, nausea and vomiting, muscle soreness, injury to the eyes. Further, I understand instrumentation in the mouth to maintain in open airway during the anesthesia might unavoidably result in dental damage including fracture or loss of teeth, bridgework, dentures, crowns and fillings, laceration of the gums or lips. I understand that medications that I am taking may cause complications with anesthesia or surgery. I understand that it is in my best interest to inform my doctors about the nature of any medications I am taking including but not limited to aspirin, cold remedies, narcotics, PCP, marijuana, and cocaine.

I understand that my anesthesia care will be given under the supervision of an anesthesiologist or CRNA. My doctor has informed me that the proposed/planned anesthesiology service may not be reimbursable under my current insurance plan, based on the plan's medical necessity guidelines. **If my anesthesia services are not reimbursed by my current insurance, I agree to pay the $125 cash pay rate.** I have advised the doctor to proceed with the performance of this service. A claim may be submitted to my insurance carrier for reimbursement to be paid to the anesthesiologist or CRNA. In the event that the anesthesiologist or CRNA does not participate with my insurance plan, payment for services may be sent directly to me, the subscriber. I agree to forward all payments for the anesthesia services to Anda upon receipt. I also assume responsibility for all co-pay, co-insurance and deductible amounts for out-of-network benefits. I have requested services and will become fully financially responsible for all charges incurred in the course of treatment authorized, including any interest charges incurred if the billing process is delayed due to failure to cooperate.

By signing this document, I am indicating that I understand the contents of this document and its attachments agree to its provisions and consent to the administration of anesthesia during my procedure/operation/treatment. I know that if I have concerns or would like more detailed information, I can ask more questions and get more information from my attending physician. I am also acknowledging that I know that the practice of anesthesiology, medicine and surgery is not an exact science and that no one has given me any promises or guarantees about the administration of anesthesia or its results. I fully understand what I am now signing of my own free will.

X _____ _____
Patient Signature Date of Service

X _____ _____
Patient Name (PRINTED) Date of Birth

I attest this patient or the representative named above has been informed about the common foreseeable risks and benefits of undergoing the anesthetic and related problems as well as its reasonable alternative(s), is any. Further questions with regard to this anesthetic and related procedures have been answered to his/her apparent satisfaction.

_____ _____
Anesthesiologist/CRNA signature Date of service

_____ _____
Witness Date of service