GARDEN STATE ENDOSCOPY & SURGERY CENTER
200 Sheffield Street, Suite 101, Mountainside, NJ 07092 908-241-8900

Patient Name: _____DOB:_____

Procedure: _____

Performing MD: _____

PROCEDURE CONSENT

I hereby authorize **<Performing MD>** and/or such assistant(s) as may be selected by him to treat the condition(s) which appear indicated by the diagnostic studies already performed. The procedure(s) necessary to treat my condition(s) has/have been explained to me and I understand the nature of the procedure(s) to be:

Colonoscopy/ Anoscopy/ Flexible Sigmoidoscopy: the visualization of the large intestine with a flexible video or fiberoptic telescope with the possible removal of polyp(s), possible biopsy or cautery of any suspicious tissue, and/or control of any bleeding site, possible marking of the intestine to relocate suspicious sites possible ligation, excision, and/or sclerosis of hemorrhoids.

Upper Endoscopy: the visualization of the esophagus, stomach, and duodenum with a flexible video or fiberoptic telescope, removal of polyp(s), biopsy or cautery of any suspicious tissue, injection therapy or rubber band ligation to control any bleeding sites, and dilation (stretching) of narrow areas.

Percutaneous Endoscopic Gastrostomy (PEG): upper endoscopy and insertion of a feeding tube through the anterior wall of the abdomen.

Removal/Replacement of feeding tube (PEG)

Paracentesis: A trocar or large needle is inserted into the peritoneal cavity of the abdomen under local anesthesia to remove ascetic fluid

Other Procedure: _____

1. Consent to photograph/videotape: I understand that during the course of the procedure(s), photograph or videotape recordings may be taken of the procedure or specimen. They will be maintained as part of the facility and/or physician's confidential record. I consent to the aforementioned providing that my confidentiality is not compromised.

2. I consent to the administration of sedation/anesthesia by or under the direction/supervision of Dr. **<Performing MD>**

3. I recognize that, during the course of the procedure(s), unforeseen conditions may necessitate additional or different procedure(s) than set forth in paragraph 1. I therefore authorize and request that the above-named physician, his assistant(s), or his designee(s) perform such procedure(s) as are in the exercise of professional judgment necessary and desirable. If there is any question that I might be pregnant, I will allow urine pregnancy testing to be performed prior to my procedure. The authority granted under this paragraph 4 shall extend to treating all conditions that require treatment and are not known to the physician at the time the procedure(s) is/are commenced.

4. I have been made aware of the risk(s) and consequences that are associated with the procedure(s) described in paragraph 1. These include ***bleeding, perforation, and adverse reactions to medications and missed lesions.***

5. I have been informed of the other risk(s) such as severe blood loss, infection, cardiac or respiratory arrest, etc., that are attendant to any procedure. 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 results of the procedure(s), and I have further been informed of the alternative(s).

6. I have been made aware that a consultant/medical student or fellow or representative of a medical company might be present in the room during my procedure.

7. I hereby give permission to the Center to dispose of any tissue removed in the course of the procedure(s) in accordance with policy.

8. I understand that I should not drive for twenty-four (24) hours following my procedure. I also understand that in the event of cardiac arrest or respiratory arrest or other life-threatening situation during my admission, the center will perform necessary life saving measures until transferred to a hospital should such methods become necessary and that my Advance Directives will not be honored at Garden State Endoscopy and Surgery Center. I give my consent for any medical treatment deemed necessary including transfer to a higher level of care.

9. I consent to the drawing and testing of my blood in the event that an individual is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential, expect as specified by law.

10. I consent to having a peer physician review my medical record to obtain information about the delivery of medical care.

Alternatives to Gastrointestinal Endoscopy

Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, no test is 100% accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or a misdiagnosis 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 discuss these options with you.

_____ _____

PATIENT/AUTHORIZED PERSON DATE

_____ _____

WITNESS DATE

I hereby certify that the risks and benefits of the proposed procedure/treatment as well as the alternatives have been explained to the patient or responsible other.

_____ _____

SIGNATURE: PHYSICIAN DATE

Garden State Endoscopy & Surgery Center
PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The Center is an "Ambulatory Surgery Center" specially designed for the practice of Gastroenterology --- no other medical procedures are performed here. The mission of the Center is to provide quality care in a specialized outpatient setting and we strive to provide each patient with the utmost care and personalized attention.

Please be aware that some of the physicians performing procedures may have a direct financial ownership interest in this center.

In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take a minute to read the following and discuss any questions you may have with our billing representative.

1. The fee that we charge for our services covers the non-professional component of your procedure also known as the "technical" or "facility" fee which includes the cost of operating this facility including equipment, staff, rent, supplies, etc. You will also receive a separate bill from the physician's office for their professional services, anesthesia services, and possibly the laboratory for any pathology services. The facility, laboratory, and physicians' professional office are all separate legal entities providing separate and distinct services.
2. As a courtesy to our patient's, insurance claims will be submitted on the patient's behalf to the insurance company specified during the registration process as long as we have the complete name and address of the insurance company, the subscriber's name, social security number and birth date, and the group number and any other required pre-authorization for the procedure.
3. We expect all known co-payments to be paid at the time of service or as required by the contract between the patient, the insurer, and our center. We reserve the right to collect co-pays, deductibles, and coinsurance upon notification by the insurer.
4. Some insurers require pre-certification, pre-authorization, or a written referral. It is the patient's responsibility to understand the insurance plan requirements and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial of the claim by the insurer. If your insurance denies the claim, or holds payment, you may be ultimately responsible for the balance.
5. If you have any questions related to the balance, please contact our Billing Office to discuss your account. Non-payment will result in referral to an outside collection agency that could impact the patient's credit record. Legal fees and collection costs incurred to collect outstanding accounts will be the patient's responsibility.

Patient has Advance Directive ☐ YES ☐ NO

Patient Advance Directive provided to the Center and placed in Medical Record ☐ YES ☐ NO

Advance Directive information was provided to the patient by the center. ☐ YES ☐ NO

Prior to the initiation of the procedure, the patient received a brochure and verbal information outlining the Patient's Rights and Responsibilities and the facility's policy on advance directives. ☐ YES ☐ NO

Authorization to Release Information: I hereby authorize Garden State Endoscopy & Surgery Center, to release any and all information necessary for the billing and processing of the account for services rendered.

I understand I should not bring any valuables to Garden State Endoscopy & Surgery Center and that the center is not liable for the theft or loss of valuables.

Assignment of Insurance Benefits: I hereby authorize payment to Garden State Endoscopy & Surgery Center insurance benefits, otherwise payable to me, for this service. Payment to Garden State Endoscopy & Surgery Center shall not exceed the balance due for services rendered.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility. I understand that I am financially responsible to the center for charges not covered by this assignment.

Patient's Name (printed):_____

PATIENT SIGNATURE: _____

CENTER REPRESENTATIVE SIGNATURE: _____

Garden State Endoscopy & Surgery Center
Patient Consent and Acknowledgement of Privacy Practices

For Use and/or Disclosure of Protected Health Information to Carry Out Treatment, Payment and Healthcare Operations

<Patient name>, hereby states that by signing this Consent, I agree and acknowledge the following:

1. The Notice of Privacy Practices ("Privacy Notice") for Garden State Endoscopy & Surgery Center (the "Center") has been provided to me prior to my signing this Consent. The Privacy Notice includes a description of the permissible uses and/or disclosures of my protected health information ("PHI") by the Center. I understand that a copy of the Privacy Notice will be available to me in the future at my request. The Center has encouraged me to read the Privacy Notice carefully prior to my signing this Consent. The Center reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

2. I understand that, and consent to, the following appointment reminders that will be used by the Center:

3. A postcard mailed to me at the address provided by me; and/or
    a. Telephoning my home and leaving a message on my answering machine.
    b. Telephoning my cellphone or leaving a text message
    c. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described in the Privacy Notice, then the Center will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Signature Patient or Legal Representative_____

Signature Witness_____