Anesthesia Consent

Consent for services provided by ***Outpatient Anesthesia Specialist LLC***

I here by authorize and direct ***Outpatient Anesthesia Specialist LLC***. and individual anesthesia provider to care for me, and administer those medications deemed necessary to render me insensible to pain and the recollection of this procedure.

I understand that the medications used are widely accepted for this procedure and are given to me in order that I may tolerate this procedure with little or no discomfort. I further understand and agree that in order to achieve this goal I may for short periods of time during the procedure be unaware of my surrounding, insensible to word, or the stimulation and pain caused by the procedure.

Although rare, unexpected complications with anesthesia can occur and include the remote possibility of dental trauma, sore throat, depressed breathing, unconscious state, drug and/or allergic reaction, aspiration pneumonitis (infection of the lungs) and on very rare occasions you may require additional respiratory support and intervention due to increased sedation. Like with all interventions there is a risk of exacerbating an underlying medical condition such as, heart or lung problems. There have also been reports of death (exceedingly rare) associated with the use of anesthesia.

It is the understanding of the undersigned that the nurse anesthetist will have full charge of the administration
of the medication and techniques used to maintain my comfort, and that this is an independent function from the procedure I am having done. Unless otherwise indicated by the physician and discussed with me prior to the procedure, I understand ***Outpatient Anesthesia Specialist LLC.***will be administering intravenous Propofol or other medications deemed necessary by anesthesia personnel or physician.

Lifetime Authorization for Medicare/Insurance Certification for Payment

I certify that the information given for payment under Title XVII of the SSA is correct. I authorize ***Outpatient Anesthesia Specialist LLC.*** and their agents and contractor's to use this signature as a release to the Social Security Administration or it's intermediaries or carriers, or to the billing agent of anesthesia claims or suppliers, any information needed for this or a Medicare claim. I request that the benefits be made on my behalf. I permit a
copy of this be used in place of the original. I may revoke this authorization by notifying ***Outpatient Anesthesia Specialist LLC i***n writing. I request that this authorization apply to all insurance.

Medigap Authorization

I request that payment of authorized Medigap benefits be made on my behalf to ***Outpatient Anesthesia Specialist LLC*** and their agents and contractors for any services furnished to me. I authorize any holder of medical information about me and or information needed to determine these benefits payable for related services to release it to my Medigap insurer.

THIS IS A COPY OF THE ORIGINAL FORM TO BE SIGNED THE DAY OF PROCEDURE