Raleigh Endoscopy Center, LLC

<u>Authorization for and Consent to Procedure</u>

I, _______________________________, consent to allow my physician: ________________________, and any other assisting physicians and surgical personnel as requested by my physician to perform the following procedure:
____

My physician has explained to me the nature and purpose of the procedure that will be performed. I understand 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 this procedure. Additionally, I authorize the performance of any other procedures that in the judgment of my physician or other healthcare providers participating in the procedure may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

My physician has explained to me the risks and/or complications, benefits, and medically acceptable alternatives to the procedure. X-ray studies may be an alternative, but x-rays do not allow for direct visualization of tissue nor do they allow for removal of tissue specimens or polyps if necessary. The potential risks or complications of this procedure include but are not limited to infection, adverse reaction to medication, dental trauma, injury to organs, perforation, bleeding, cardio/respiratory complications, and death that are attendant to the performance of any procedure. In a small percentage of patients, a failure of diagnosis or a misdiagnosis may result.

I understand that there are risks with any procedure, and it is impossible for the physician to inform me of every possible complication. I have elected to proceed after being advised of this information and having all of my questions answered to my satisfaction.

I understand that anesthesia services are being provided by anesthesia provider and I will sign a separate consent form for those services. In the event my physician, anesthesia provider, staff, or other patient is exposed to my blood, bodily fluids, or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

<u>I have been given the opportunity to ask questions about the procedure that will be performed. I have been given explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives and I enter into this contract to consent to the surgery or procedure freely</u>.

The undersigned certifies that he/she has read the foregoing and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

____	_______________________	___________________
Patient and/or legal Guardian's signature	Relationship	Date/Time

____	___________________
Witness to above Signature	Date/Time

Physician Statement: I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the surgery/procedure and have allowed the patient/responsible adult to ask questions.

____	___________________
Physician Signature	Date/Time

<Patient Name>
<MRN>
<DOB>