Parkway Endoscopy Center _____

Consent for Treatment

1. I, {@FirstName} {@LastName}, voluntarily authorize Doctor {@DrLastName} and such associates, technical assistants, and other health care providers as he may deem necessary, to perform the following procedure(s):
   {@ProcedureName}.
2. Risks, benefits, and alternatives of this procedure have been explained to me. I have had opportunity to have my questions answered.
3. I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician and staff to perform such other procedures, which are deemed advisable in their professional judgment and competency.
4. I understand that there are risks and hazards related to the procedure such as damage to the intestinal lining from the instrument, aspiration, reactions to medication, gas pains, perforation of bowel or esophagus, infection and bleeding.
5. I understand that conscious sedation involves additional risks and hazards but I request the use of sedation for the relief of pain and anxiety during the procedure(s). I understand that certain complications may result from the use of conscious sedation medications including respiratory problems, drug reactions and even death.
6. I acknowledge that I have been advised not to drive until the effects of any medication have worn off. This means I should not drive until the day after my procedure, at the earliest.
7. I understand that if I am pregnant or if there is any possibility that I may be pregnant, I must inform the Parkway Endoscopy Center immediately since this could cause harm to my child or myself.
8. In the event the physician or staff is exposed to my blood, body fluids or contaminated materials, I agree to allow testing that will determine the presence of Human Immunodeficiency Virus Type I (HIV) and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.
9. I understand that advance directives are not honored at the Parkway Endoscopy Center and in the event of an emergency or life threatening situation, advanced cardiac life support procedures will be instituted in every instance and patients will be transferred to a higher level of care.
10. I have been informed of my rights to formulate a Living Will and Advance Medical Directive. I have received information on Living Will/Advanced Directives, and I understand that I am not required to have either in order to receive medical treatment at this health care facility.
    - ☐ Yes, I do have a Living Will/Advance Directive located at _____.
    - ☐ No, I do not have a Living Will/Advance Directive.
11. I am aware that the physician may take clinical photographs during my procedure which will become a part of my permanent record. I consent to clinical photographs during the procedure.
12. I understand that occasionally physicians will bring Medical Equipment Representatives and medical professionals into the procedure room. I understand and consent to their presence.
13. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the results or success of this procedure.

Date:

Patient Signature: _____
(or legal representative/guardian and relationship)

Witness Signature:_____