

**FIFTH AVENUE MEDICAL GROUP, LLC**

835 Fifth Avenue  
Chambersburg, PA 17201  
717/263-0629

**ANESTHESIA CONSENT FORM**

I hereby request, authorize and give my consent to the below-named Certified Registered Nurse Anesthetist or Fifth Avenue Medical Group, LLC for the administration of anesthesia and/or monitoring for my procedure. I understand that my physician will consult with and decide with them as to the most appropriate type of anesthetic for my particular procedure, my safety and my comfort. If any unforeseen circumstances should arise which, in the best judgement of my nurse anesthetist/anesthesiologist and physician or surgeon, require deviation from the original anesthetic plan, I further authorize that whatever other anesthetics or emergency procedures deemed advisable by them may be administered or performed. I understand that anesthesia carries with it certain risks, hazards and side effects of which I have been made aware, even when administered without any error on the part of the anesthesia personnel whatsoever.

I understand that the anesthesia medications I am to receive may cause temporary side effects postoperatively such as, but not limited to, dizziness, drowsiness, hiccoughs, nausea and/or vomiting, pain, redness or bruising at the site of the intravenous catheter.

With these understandings, I accept full responsibility for myself by agreeing to indemnify Fifth Avenue Medical Group, LLC, its directors, shareholders, employees and subcontractors from any liability related to these potential side effects or any other side effects or complications. In addition, I have been advised not to drive a motor vehicle or participate in any potentially dangerous activity for at least 24 hours afterwards.

I have been given the proper opportunity to have all my questions answered regarding the anesthesia and they have all been answered in a satisfactory manner.

**ASSIGNMENT OF INSURANCE BENEFITS**

I authorize and assign the health insurance benefits to which I am entitled to Fifth Avenue Medical Group, LLC (hereinafter known as "Providers") for their services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that my plan may not compensate my Providers for their anesthesia services and I will, therefore, be totally responsible for all charges. I hereby authorize the Providers, to whom I assign benefits, to release any information about me necessary to process their claim. In the event that this account must be assigned to collection, I agree to pay all costs including reasonable attorney fees. In addition, I hereby grant a lien to these Providers against any settlement, claim, judgment or verdict I may receive as a result of my accident for the payment of Provider's bills.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
CRNA/ANESTHESIOLOGIST

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness