CHAMBERSBURG ENDOSCOPY CENTER, LLC

835 Fifth Avenue, Chambersburg, PA 17201

Date of Procedure: ___________________

Consent for Surgery/Invasive Procedure

(*Do **not** sign without reading*)

Name: ___________________________________ Date: _______________________ Time: _______________ A.M. / P.M.

____ will be performing a colonoscopy under sedation/analgesia and/or total IV anesthesia with performance of polyp removal and/or biopsies as necessary.
Name of Physician

____ Yes — It has been explained to me how the procedure will be done and what to expect.

____ Yes — It has been explained why this procedure was recommended to me.

____ Yes — It has been explained the available alternatives and choices to this procedure, as well as the risks of not having the procedure done. These include but are not limited to: Alternatives: Barium enema, sigmoidoscopy. Risks of not proceeding with this study include failure to diagnose cause for symptoms. I have been fully informed in general terms of the risks, benefits, and alternatives associated with having the procedure at Chambersburg Endoscopy Center instead of a hospital.

____ Yes — I have been provided an explanation of the known and recognized risks to this procedure.

Specific risks include but are not limited to: bleeding and perforation (uncommon), heart attack, stroke, breathing difficulties or medication reaction (rare complications).

____ Yes — I have had an opportunity to ask questions.

____ Yes — I have had my questions answered and I believe I have all the information I need to fully agree to this procedure.

____ Yes — I have read and understand this form and truthfully answered all questions.

____ Yes — I consent to the procedure.

____ Yes — Patient Self-Determination Act of 1990/Advance Directives: Chambersburg Endoscopy Center has made available to me written information on my rights and responsibilities to make health care treatment decisions in compliance with the Patient Self-Determination Act of 1990. I also understand that I am consenting to have an elective procedure performed upon me at this facility; therefore, Chambersburg Endoscopy Center will not honor Advance Directives (Living Wills).

____ Yes — Personal Valuables: Chambersburg Endoscopy Center provides facilities for the safekeeping of any valuables and any valuables kept by the patient are kept at the patient's risk. I hereby accept full responsibility for any personal effects taken to the procedure room, including such things as dentures, eyeglasses, contact lenses, hearing aids.

____ ____
Signature of patient or person authorized to consent for patient — Signature of Witness

I certify that the patient/parent/guardian or other legally responsible person has been provided information on the risks and hazards, Benefits and alternatives to treatments outlined above, had questions within my area of expertise answered and has given consent.

_____/_____/_____ ________________ _____________________________________
Date — Time — Signature of Physician