ENDOSCOPIC SURGICAL CENTRE OF MARYLAND, LLC
10801 Lockwood Drive, Suite 110
Silver Spring, MD 20901
Voice: (301) 593-5110 Fax: (301) 593-6269
TTY Users Call Maryland Relay #711

Lab Corp Account #: 19517490 Quest Account #: 53076104

Authorization for and Consent to Procedure

I consent to allow my physician, Dr. {appointment providers: prefix firstname middleinitial lastname suffix title} , and such other assisting physicians and center personnel as requested by my physician to perform the following procedure(s):

______Esophagogastroduodenoscopy (EGD) with Possible Biopsy/ Polypectomy /Dilatation

______Colonoscopy with Possible Biopsy and/ or Polypectomy

______Flexible Sigmoidoscopy with Possible Biopsy and/ or Polypectomy

______IRC (Infra- Red Coagulation of Hemorrhoids)

______Banding of Hemorrhoids

______Other:____

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. The potential risks or complications of this procedure include infection, adverse reaction to medication, dental trauma, bowel perforation, injury to organs, bleeding, cardio/respiratory complications, and death that are attendant to the performance of any surgery/procedure. In a small percentage of patients, a failure of diagnosis or a misdiagnosis may result.

I understand that there are risks with any surgery or 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.

{patientlastname} , {patientfirstname} , {patientmiddleinitial}
Account # {patientMRN} DOB: {patient dob short}

Dr. {appointment providers: prefix firstname middleinitial lastname suffix title}
Appointment Date/Time: {appointment date} {appointment time}

I understand that anesthesia services, if needed, are being provided by an 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.

I consent to the taking of endoscopic photos which will become part of the medical record and, at times, might be used for teaching and or publication purposes, provided my identity will not be revealed by either the pictures or any written description which may accompany them. Permission is granted for a manufacturer's representative, for technical assistance, or a student, for continuing education, a visiting physician, as well as federal, state or accrediting body surveyors to be in attendance during my procedure if the situation arises.

I have been given the opportunity to ask questions about the procedure(s) 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 procedure(s) freely. ____________ (initial)

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 Signature Date/Time

____ _____________________________
Patient Representative Signature / Relationship Date/Time

____ _____________________________
Witness Signature Date/Time

Physician Statement

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

____ _____________________________
Physician Signature Date/Time

{patientlastname} , {patientfirstname} , {patientmiddleinitial}
Account # {patientMRN} DOB: {patient dob short}
Dr. {appointment providers: prefix firstname middleinitial lastname suffix title}
Appointment Date/Time: {appointment date} {appointment time}

Endoscopic Surgical Centre of Maryland

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

I understand that I may receive up to four (4) separate statements for my procedure, including statements from the Endoscopic Surgical Center of Maryland (facility fee), Capital Digestive Care (physician's fee), Our Anesthesia Providers (anesthesia fee), and Laboratory/Pathology fee (if specimens are taken during the procedure). Self-pay patients are expected to pay the agreed upon balance at the time of service.________________(initial)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Endoscopic Surgical Centre of Maryland, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Endoscopic Surgical Centre of Maryland may have an ownership interest in Endoscopic Surgical Centre of Maryland. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Endoscopic Surgical Centre of Maryland.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding Endoscopic Surgical Centre of Maryland's policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize the Endoscopic Surgical Centre of Maryland and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/with:

- My spouse/family member/other Name(s): ________________________________ ________Initials
- Leave a message on my answering machine: Yes_______ No_______ ________Initials

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

________________________________	________________________________
Signature of Patient or Responsible Party	Print Name
________________________________	________________________________
Relationship to Patient	Date Signed

{patientlastname} , {patientfirstname} , {patientmiddleinitial}
Account # {patientMRN} , DOB {patient dob short}
Dr. {appointment providers: prefix firstname middleinitial lastname suffix title}

Appointment Date/Time: {appointment date} {appointment time}