INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

Explanation of Procedure

Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures.

At the time of your examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may be removed.

To keep you comfortable during the procedure, your physician or a Nurse directed by the physician will administer medication defined as Moderate (Conscious) Sedation. If deemed necessary by your Physician, an Anesthesiologist will be present to administer sedation.

Brief Description of Endoscopic Procedures

1. **EGD (Esophagogastroduodenoscopy):** Examination of the Esophagus, stomach, and duodenum. If active bleeding is found, treatment may be given to stop bleeding.
2. **Esophageal Dilation**: Dilating tubes or balloons are used to stretch narrow areas of the esophagus.
3. **EIS (Endoscopic Injection Sclerotherapy)**: Injection of a chemical into varices (dilated varicose veins of the esophagus) to sclerose (harden) the veins to prevent further bleeding. Injection is done with a small needle probe though the endoscope.
4. **Variceal Banding**: The physician places a latex (rubber) band around the varices to reduce the flow of blood to the vein, thus preventing further bleeding.
5. **Flexible Sigmoidoscopy**: Examination of the anus, rectum and left side of the colon, usually to a depth of 60 cm.
6. **Colonoscopy**: Examination of all or a portion of the colon. Older patients and those with extensive diverticulosis are more prone to complications. Polypectomy (removal of small growths called polyps) is performed, if necessary, by the use of a wire loop and electric current.
7. **Other Procedures: Liver Biopsy, Phlebotomy, and Esophageal Motility &/or 24 hr pH.**

Principal Risks and Complications of Gastrointestinal Endoscopy

Gastrointestinal endoscopy is generally a low risk procedure. However, all of the following complications are possible. Your physician will discuss their frequency with you, if you desire, with particular reference to your own indications for gastrointestinal endoscopy. ***YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR TEST***.

1. **Perforation**: Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required and may necessitate the need for a colostomy; which is a bag on your abdomen that stool would come through for a temporary amount of time.
2. **Bleeding**: Bleeding, if it occurs, is usually a complication of biopsy, Polypectomy or dilation. Management of this complication may consist only of careful observation, or may require transfusions, repeat endoscopy to stop the bleeding or possibly a surgical operation.
3. **Medication Phlebitis**: Medications used for sedation may irritate the vein in which they are injected. This causes a red, painful swelling of the vein and surrounding tissue. The area could become infected. Discomfort in the area may persist for several weeks to several months.
4. **Other Risks**: Include drug reactions, complications from other diseases you may already have, not being able to complete the exam, and the possibility of missing a colon cancer. Instrument failure and death are extremely rare but remain remote possibilities. ***YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS.***

Alternatives to Gastrointestinal Endoscopy

Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or misdiagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

Physician explaining procedure: _________________________ M.D.Signature: _____________________________________Date: ____________

I understand that because of the sedation I may not drive or operate machinery, make critical decisions, sign legal documents or consume alcoholic beverages the day of the procedure. I have been fully informed of the risks and possible complications of my procedure/anesthesia and have been given the opportunity to ask questions.

I hereby authorize and permit:

☐ Alan Chang, MD	☐ Stephen Woods, MD	☐ James Schoenecker, MD
☐ Donald Wadland, MD	☐ Christoph Reitz, MD	☐ Todd Witte, MD
☐ Barry Levenson, MD	☐ Kelly McCullough, MD	

☐ Upper Endoscopy (EGD), with possible biopsy ☐ Flexible Sigmoidoscopy ☐ Esophageal Dilation

☐ Colonoscopy, with possible biopsy or polypectomy ☐ Variceal Banding ☐ Other____________________________

I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named Physician, his assistants or designees may perform such procedures as necessary and desirable in the exercise of his/her professional judgment. I understand the Endoscopy Center <u>does not</u> recognize Do Not Resuscitate orders and will use all measures possible to sustain life. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of this procedure.

____ _______________________________________

☐ **Patient** / ☐ **Legally Authorized Representative** (check one) **Relationship to Patient**

Date:____________________________ **Time:** ________________ **Witness of Signature only:**________________________

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[ ] Kelly McCullough, MD
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INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

The Center was established to meet the special needs of patients with gastrointestinal complaints or diseases. It is an "Ambulatory Surgery Center" specially designed for the practice of Gastroenterology - no other medical procedures are performed here. The physicians providing services at our facility are all Gastroenterologists and our clinical staff are trained professionals experienced in caring for our patients. The mission of the Center is to provide quality care to our patients in a specialized outpatient setting. Each patient will have our utmost careful and personalized attention.

The Center is jointly owned by Physicians Endoscopy, LLC and Northwest Gastroenterology, PLLC. The physicians of Northwest Gastroenterology, PLLC are the sole medical providers of the Center.

In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take time to read the following and discuss any questions you may have with one of our billing representatives.

1. The fee that we charge for our services is intended to cover the cost of operating this facility including equipment, staff, rent, supplies, etc. There will also be a separate charge from the physician for their professional services, as well as from the laboratory for any pathology services. The facility, laboratory and physicians are all separate legal entities providing separate and distinct services.

2. As a courtesy to our patients, insurance claims will be submitted on the patient's behalf to the insurance company(s) specified during the registration process; provided we have the complete name and address of the insurance company, and the subscriber's name, social security number and birth date.

3. All co-payments are due and collected at the time of service as required by the contract between the patient, the insurance company and our center.

4. Some insurance plans require pre-certification, pre-authorization or a written referral. It is the patient's responsibility to understand their insurance plan requirements and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial of the claim by the insurance company. We cannot accept responsibility for a disputed claim. If your insurance company denies the claim for any reason or withholds payment, you are ultimately responsible for the balance.

5. We recognize that there may be times when full payment is not possible. Patients without insurance are expected to pay a minimum of 50% of the cost at the time of service and a minimum of one-third of the remaining balance over each of the three months following the date of service.

6. If you are having financial difficulty or have questions please contact our Billing Office at **(360) 734-1420 option 6,** to discuss your account. Payments are expected to be paid monthly. Non-payment of accounts after three months may result in referral to an outside collection agency that could impact the patient's credit record.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility and

that regardless of any insurance coverage I may have, I am ultimately responsible for payment of my account with the Center.

Patient's Name: ___________________________________
(printed)

Patient's Signature: _____________________________________ Date: ________________________________

Center Representative: ___________________________________ Date: _______________________________