

STATEMENTS

1. If applicable to my procedure, I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic or educational use.
2. I consent to treatment and any additional services deemed medically necessary for the procedure including but not limited to, anesthesiology, radiology, and pathology, implant of medical devices or intraocular lens, and administration of blood and/or blood products in the event of a life threatening emergency; excluding Gastroenterology procedures and patients admitted to the Griffin Road campus. Independent physicians are contracted to provide anesthesia, radiology, pathology, and other services.
3. I understand that I am required to have a competent companion accompany me after my surgery and that I will be discharged to that person's custody and must rely on him or her for my return home and supervision as instructed.
4. If applicable to my procedure, I understand that due to the Safe Medical Devices Act my social security number will be disclosed to the appropriate regulatory agency as required.
5. I certify that I fully understand the proposed procedure, the risks, the alternatives and the consequences of not having it and do consent to the procedure. I further certify that I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.
6. In the event of blood or fluid exposure to medical personnel involved in my care, I authorize and consent to the drawing of my blood for the purpose of conducting HIV or Hepatitis testing. In the event that such exposure does occur, I will be notified. I understand that the test is not 100% reliable and may, in some cases, indicate a false positive or a false negative. A second test may be necessary to confirm results. If there is a positive test result, health care practitioners directly responsible for my care will be informed of this result so that proper treatment can occur.
7. I acknowledge prior written and verbal notice that my physician may be a shareholder in this ambulatory surgery center and is not an employee of Lakeland Surgical & Diagnostic Center, LLP. I understand that I am free to choose another facility in which to receive the services that have been ordered by my physician.
8. I understand that this facility is an ambulatory surgery center and my physician has determined that the procedure can be performed in this facility. I understand that if an emergency medical condition should occur, I will be transferred to the closest hospital for further evaluation and treatment. I consent to the release of medical records from the hospital's admission, to the center. I understand that if I have an advance directive or living will, the ambulatory surgery center will still transfer me to the closest hospital per company policy. I have been given prior written and verbal information regarding advance directive policies and the opportunity to complete an advance directive form(s):
 Declined **Given to Patient** **On File** (obtain copy from prior medical record and place in active chart)
9. **FINANCIAL AGREEMENT:** I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers).

Patient Consent / Business Office

10. Whether signing as the patient or his/her legal surrogate, I agree that in consideration of the services rendered, I shall be personally responsible to pay the Center for all such services, at the Center's standard rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles, co-pay, co-insurance or out-of-pocket responsibilities owed at the time of services. Should this account be referred to a collection agency, I understand that I will be responsible for all collection expenses and attorney fees along with the balance of the patient's delinquent account balance.

11. I hereby certify that the insurance information provided in applying for payment under Titles XVIII and XIX of the Social Security Act or by any other payer is correct. I assign to the Surgery Center all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services.

12. I understand that I was instructed not to bring any personal belongings on the day of my procedure and I shall be responsible for any personal items that I have brought in contrary to instructions given. I further agree to hold Lakeland Surgical & Diagnostic Center, LLP harmless in the unlikely event of loss or damage of personal items during my stay at the center.

13. I acknowledge written and verbal receipt of Lakeland Surgical & Diagnostic Center's Policies on Patient Rights in advance of the date of the procedure to include notice of rights, physician financial interests or ownership in the ASC, advance directives, submission and investigation of grievances, exercise of rights and respect for property and person, privacy and safety, and confidentiality of clinical records as outlined in CFR 416.50 and the Florida Patient's Bill of Rights and Responsibilities as outlined in FS 381.026.

Patient Signature

Date

Witness Signature

Patient Consent / Business Office

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I understand that anesthesia services are needed so that my doctor can perform my operation or procedure. It has been explained to me that all forms of anesthesia involve some risks, and no guarantees or promises can be made concerning the results of *my* procedure or treatment. **RARE, SEVERE, UNEXPECTED COMPLICATIONS CAN OCCUR WITH EACH TYPE OF ANESTHESIA, INCLUDING THE POSSIBILITY OF INFECTION, BLEEDING, DRUG REACTIONS, BLOOD CLOTS, LOSS OF SENSATION, LOSS OF VISION, LOSS OF LIMB FUNCTION, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK OR DEATH.** I understand that these risks apply to ALL forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique that involved the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used, including general anesthesia.

<input type="checkbox"/> General Anesthesia	Expected Result	Total unconscious state, possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks (include but not limited to)	Mouth, throat, or nose pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, vomiting, aspiration, pneumonia, corneal abrasion.
<input type="checkbox"/> Major/Minor Nerve Block (local) <input type="checkbox"/> With sedation <input type="checkbox"/> Without sedation	Expected result	Temporary loss of feeling and/or movement of a specific limb or area.
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation.
	Risks (include but not limited to)	Infection, convulsions, weakness, persistent numbness, residual pain requiring additional anesthesia, injury to blood vessels, failed block.
<input type="checkbox"/> Intravenous Regional Anesthesia (with sedation)	Expected result	Temporary loss of feeling and/or movement of a limb, reduced anxiety.
	Technique	Drug injected into veins of arm or leg while using a tourniquet.
	Risks (include but not limited to)	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels.
<input type="checkbox"/> Monitored Anesthesia Care (with sedation)	Expected result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes, producing a semi-conscious state.
	Risks (include but not limited to)	An unconscious state, depressed breathing, injury to blood vessels.
<input type="checkbox"/> Monitored Anesthesia Care (without sedation)	Expected result	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None.
	Risks (include but not limited to)	Increased awareness, anxiety and/or discomfort
<input type="checkbox"/> Moderate Sedation (IV Conscious Sedation)	Expected result	Reduced anxiety and pain; partial or total amnesia
	Technique	Drug injected into blood stream
	Risks (include but not limited to)	An unconscious state, depressed breathing, injury to blood vessels
<input type="checkbox"/>	Expected result	
	Technique	
	Risks (include but not limited to)	

I consent to the anesthesia service checked above and authorize that it be administered by my physician or consulting anesthesiologist, which may include certified registered nurse anesthetists under the supervision of the anesthesiologist, all of whom are credentialed to provide anesthesia services at Lakeland Surgical and Diagnostic Center. I understand that circumstances may occur which require changing my planned anesthesiology provider. I understand the importance of providing my health care providers with a complete medical history, including the need to disclose any medications that I am taking, both prescription and over the counter. I also understand that my use of herbal remedies, alcohol or any type of illegal drug may give rise to serious complications and must also be disclosed. I further understand that I should also disclose any complications that arose from past anesthetics. I acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Signature

Date

Parent/Guardian Signature (if Applicable)

Relationship to Patient

Anesthesiologist/Physician Signature

Anesthesiologist/Physician Name

CONSENT FOR ANESTHESIA

Consent to Surgery or Other Medical Procedures

Patient Name: _____

I authorize Dr. _____ or his/her designee to perform the procedure as indicated.

I understand that in order for me to make an informed decision about undergoing surgery or other medical procedures, I should have certain information about the proposed surgery or procedure, the risks associated with it, the alternatives and the consequences of not having it.

My physician has proposed the following PROCEDURE to treat or diagnose my condition:

I understand that the following practitioner(s) will be involved in the procedure, and will perform those parts of the procedure listed: (list name, title, or specialty of those performing the procedure, and the specific parts of the surgical procedure each will perform).

My physician has explained the NATURE OF MY CONDITION as follows:

My physician has explained the following MEDICALLY ACCEPTABLE ALTERNATIVES to me:

My physician has indicated the CONSEQUENCES OF NOT HAVING THE PROCEDURE are as follows:

My physician has explained the SUBSTANTIAL AND FREQUENT RISKS AND HAZARDS of the proposed procedure as follows:

I understand that during the course of the operation or procedures, unforeseen conditions may be revealed which necessitate an extension of the procedure or a different procedure. If such a situation arises, I request that my physician perform such operations or procedures deemed appropriate in his/her professional judgment, to include remedying conditions requiring attention which are not presently known.

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Patient or Patient Representative Initials X _____

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PATIENT LABEL

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I acknowledge that complications can occur during this or any procedure. Among others, these risks include but are not limited to: death; sterility; impotency; stomach, bowel and bladder problems; pneumonia; thrombophlebitis; pulmonary embolus; cardiac arrest; stroke; paralysis; hepatitis; liver disease; hemorrhage; blindness; deafness; infection; the need for blood transfusions; psychiatric or emotional problems; hematoma; thickened scars; keloid and scar contractions; numbness; delayed healing; associated pain and discomfort.

I am aware the practice of medicine and surgery is not an exact science and certify that no guarantee or assurance has been made as to the results which may be obtained. I understand that even though the incidence of some of these complications is low, I must be informed of them according to the law in order to make an informed decision.

I agree to administration of such anesthetics as may be necessary or advisable for the procedure. I understand that anesthetics have certain risks, the most significant of which are described above. During the course of the operation or procedures, unforeseen situations may arise necessitating additional measures to be taken by the anesthesia provider. If such a situation occurs, I request that my anesthesiologist perform such measures that are appropriate in his/her judgment. These may include, but are not limited to, Cardiopulmonary resuscitation and transfer to a higher level care facility. I also understand that the maintenance of an open airway is of primary importance and that the maintenance of an open airway may necessitate instrumentation within my mouth that might unavoidably result in dental damage and/or irritation of the nose and throat. My physician or a consulting anesthesiologist, has informed me of the course of anesthesia that is recommended (if any) along with its possible risks and alternatives.

Because the use of anesthetic drugs may produce significant changes in my vital systems, I understand that "Do Not Resuscitate" or similar orders will be suspended during my operation or procedure until I have recovered from the effect of anesthesia, unless otherwise indicated below. If my primary physician is unavailable, I agree to treatment by an alternative physician.

I hereby certify that I understand the proposed procedure, the risks, the alternatives and the consequences of not having it and do consent to the procedure. I further certify that I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient or Patient Representative Signature _____ Date _____

(Relationship to Patient) _____

(Witness) _____

I certify that I or my designee have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I or my designee have answered all questions fully, and it is believed that the patient/legal representative (circle one) fully understands what was explained. I further certify that I or my designee have confirmed the procedure/site and side with the patient/legal representative.

Physician signature _____ Date _____

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PLACE PATIENT LABEL HERE

You have been scheduled by your physician to undergo the endoscopic procedure(s) checked below. The procedure(s) are generally known as an "endoscopy". An endoscope is a small flexible instrument that permits the physician to directly inspect the digestive tract. Each of the endoscopic procedure(s) involves visualization of different portions of the digestive tract. Your physician has advised you of the need to have the procedure(s). The following information is presented to help you understand the nature of, reason for, and possible results of the procedure(s).

At the time of an endoscopic procedure(s), the inside lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue may be removed (biopsy) for microscopic study. Small growths can be completely removed (polypectomy) utilizing a wire loop or forceps with or without electrocautery. Occasionally a narrowed portion of the digestive tract (stricture) will be stretched to a more normal size (dilatation), either during the initial examination or at a later time. Biopsy, cytology and polyp removal may be necessary during the endoscopic procedure(s). As reported in national studies, polyps are not always detected and the possibility of missed polyps can occur.

As with all medical procedures, an endoscopic procedure involves potential risks. Your physician is aware of these risks and has determined that the benefits likely to be derived outweigh the potential risks.

The principal risks associated with all endoscopic examinations are:

- (a) Injury to the lining or wall of the digestive tract with an instrument, which may result in a perforation of the lining or wall with leakage of body fluid into body cavities. If perforation occurs, surgery to close the leak or drain the region may be necessary.
- (b) Bleeding, usually as a complication of biopsy, polypectomy or dilatation. Bleeding may require careful observation, coagulation and therapeutic intervention, blood transfusion, or possibly a surgical operation for control.
- (c) Aspiration of stomach contents into lungs.

In addition to the risks mentioned above, there are other risks which are inherent in any diagnostic procedure. While it is not possible to mention every possible complication, other risks include drug reaction, stroke or heart attack. You should inform your physician of all your allergic tendencies and medical problems. Anesthetic drugs and medications suitable for the indicated diagnostic procedure will be administered. My physician or anesthesiologist has informed me of the course of anesthesia that is recommended along with possible risks and alternatives.

You have been scheduled to undergo the procedure(s) checked below:

____(1) **ESOPHAGOGASTRODUODENOSCOPY (EGD) AND POLYPECTOMY** - is an endoscopic examination of the inner lining of the esophagus, stomach and duodenum (the first part of the intestine). The small flexible tube is inserted into the esophagus through the mouth and throat to allow direct and detailed viewing of the desired area.

____(2) **COLONOSCOPY AND POLYPECTOMY** - is an endoscopic examination of the entire large intestine. The flexible endoscope will be inserted through the rectum (or stoma if applicable) and directly into the colon (the large intestine) to allow for direct and detailed viewing.

____(3) **DILATATION** - the stretching of a narrowed portion (stricture) of the associated digestive tract by inserting various types of instruments into and beyond the narrowed area.

____(4) **FOREIGN BODY REMOVAL** - is performed during EGD or Colonoscopy for the purpose of relieving blockage of the digestive tract by foreign body (such as meat bolus, or coin).

____(5) **SIGMOIDOSCOPY AND POLYPECTOMY** - is an endoscopic examination of the rectum and sigmoid colon regions. The flexible endoscope will be inserted through the rectum and directly into the colon to allow for direct and detailed viewing of the desired area.

I hereby authorize Dr. _____ to perform upon me the above procedure(s). I certify that I understand the proposed procedure, the risks, the alternative and the consequences of not having it and do consent to the procedure. I further certify that I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.

PATIENT SIGNATURE _____ **RELATIONSHIP TO PATIENT** _____
(Or Guardian/Responsible Party Signature)

DATE _____ **WITNESS SIGNATURE** _____

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I or my designee has answered all questions fully, and it is believed that the patient/legal representative fully understands what was explained. I further certify that I or my designee has confirmed the procedure/site with the patient/legal representative.

PHYSICIAN SIGNATURE _____

CONSENT FOR ENDOSCOPIC PROCEDURES