Gastrointestinal Specialists, Inc. GI-ASC LLC
Consent to Diagnostic/Therapeutic Procedure

I authorize Doctor: Lefton/Pilchman/Schapiro/Cheung/Lehrer/Rosa/Cohen/Kalakuntla to perform upon myself the following operation or diagnostic/therapeutic procedure:

[ ] **Colonoscopy** -Insertion of a flexible scope instrument thru the rectum into the large intestine. The performance of biopsies, polyp removal, and tissue coagulation/cautery may need to be performed.

[ ] **Endoscopy (EGD)** – Insertion of a flexible scope instrument through the mouth into the esophagus, stomach and duodenum (intestine). The performance of biopsies, polyp removal, and esophageal dilatation may be necessary to dilate esophagus and tissue coagulation/cautery may need to be performed.

[ ] **Flexible Sigmoidoscopy**: Insertion of a flexible scope instrument through the rectum into the sigmoid colon. The performance of biopsies, polyp removal, and tissue coagulation/cautery may need to be performed.

I am aware that no guarantees have be made to me concerning the results of the of the operation or diagnostic/therapeutic procedure.

If, during the course of the diagnostic/therapeutic procedure, unforeseen conditions may be revealed that necessitate change or extension of the original procedure(s) or different procedure(s) than those already explained above, I authorize and request that the above named physician, his assistants, or his designees perform such procedure(s) as are necessary and desirable in the reasonable exercise of his/her professional judgment.

I have been made aware that there are risks, discomforts, and possible undesirable consequences associated with the treatment and diagnosis of my condition, including (but not limited to) severe blood loss, infection, organ puncture/perforation, heart and lung complications, blood blots or death (complications may require hospitalization and/or surgery). I have discussed the risks vs. benefits associated with performing the procedure in the Ambulatory Surgical Center instead of the hospital. Advanced Directives will be suspended in the Ambulatory Surgery Center.

I understand that in addition to the risks explained to me, the possibility of other risks and consequences may arise. I understand that no procedure is guaranteed 100 percent, there is a small risk of missed polyps, cancer or other lesions.

I authorize the anesthesia personnel to administer certain anesthetics attendant to the procedure that I am about to undergo. The consent will apply to the administration of such anesthetics as may be considered necessary or advisable.
The risks, benefits and purpose of the administration of the anesthesia have been or will be explained to me as well as the possible alternatives which are available. I will be given the opportunity to ask my anesthesiologist further questions regarding the administration of anesthesia as it applies to my procedure.

I understand that the participating physicians may have a financial interest in the facility where the procedure(S) will be informed, and I have been offered an alternative site for the procedure(s).

In the event of an emergency transfer to the hospital is necessary, patients presenting with advanced directives will be informed their advance directive will follow then to the hospital. In which case the advanced directive will go in effect upon admission to hospital. Understanding all of the above, I intend to be legally bound by this informed consent, which I'm signing voluntary after it has been completed and after I have had the opportunity to read and fully understand it. I hereby authorize the performance of the above noted procedures). I hereby certify I have discussed and explained the procedure(s) an answered any question referring to the procedure(s) in this consent, with the individual granting consent.

_____ _____

Physician Signature Date & Time

_____ _____

Patient's Signature Date & Time

Witness to signature:_____ Date & Time_____

If consenting party is other than patient:_____

Signature Date & Time of Consenting Party

Relationship to patient:_____ If patient unable to sign, please state

reason:_____

Main Line Surgery Center
10 Presidential Boulevard, Ste 200
Bala Cynwyd, PA 19004
(610) 664-9700

Ambulatory Surgery Center
Medical Office Building, Ste 242
10800 Knights Rd
Philadelphia, PA 19114
(215) 632-3500

Barix Clinic
280 Middletown Blvd
Langhorne, PA 19047
(215) 702-7090

PROCEDURES CANCELLED WITH LESS THAN 48 HOURS NOTICE WILL BE SUBJECT TO A $200 CHARGE

UPPER GASTROINTESTINAL ENDOSCOPY PREPARATION

PATIENT NAME:_____ DATE:_____

THE NIGHT BEFORE THE PROCEDURE; DO NOT TAKE ANY FOOD OR LIQUID BY MOUTH AFTE MIDNIGHT.

YOU ARE NOT TO HAVE ANY GUM, MINTS OR HARD CANDY THE DAY OF THE PROCEDURE.

NO SMOKING (cigarettes, pipe, cigar, e-cigarette, or marijuana) ON THE DAY OF YOUR PROCEDURE!

Diabetic Patients

Please call the office or your primary physician to receive instruction regarding Insulin or diabetic medications. Please check your glucose level prior to your admission to the surgery center.

You may take cardiac, blood pressure, anxiety and respiratory medications on the morning of the procedure. **PLEASE TAKE MEDICATIONS ALLOWED WITH A SMALL SIP OF WATER. IF YOU ARE ON NHALERS FOR RESPIRATORY CONDITIONS (I.E ASTHMA) PLEASE USE THE MORNING OF THE PROCEDURE AND BRING THIS TO THE FACILITY.**

If you take arthritis medications (Motrin, Ibuprofen, Naprosyn, Celebrex, Ect.). Anti-platelet medications (Aspirin, Plavix, Aggenox, OR BLOOD THINNERS (COUMADIN), **PLEASE NOTIFY YOU DOCTOR.** These medications **WILL** need to be **STOPPED** for 5 to 7 days prior to your scheduled procedure. Please discuss this with you primary care physician and or cardiologist.

It is mandatory that you arrange to have someone accompany you to the procedure and drive you home. Anyone not having a responsible adult with them will have their procedure rescheduled.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

Should your physician determine you require diagnostic or preventive endoscopy or colonoscopy, your procedure will be performed at GI-ASC,LLC. The ambulatory surgery center is licensed by the Commonwealth of Pennsylvania, Accreditation Association for Ambulatory Health Care (AAAHC) and approved by Medicare.

The ambulatory surgical center is an outpatient facility, therefore your insurance carrier will be billed a facility fee and any outpatient copay, co-insurance and or deductible will apply based on your insurance policy. You will be responsible for any copays and co-insurances which are due at the time of service. Also, if your policy has a deductible, you may receive a bill for additional payment after the claim has been processed by your insurance company. If you are uncertain of your policy deductibles, please contact your insurance company for this information. Please be aware you may also receive bills from anesthesia, pathology and physician.

If you have questions please contact the billing department

Gastrointestinal Specialists Inc. Billing Department 215-702-0506

Anesthesia (Origin Healthcare Solutions) 201-804-5248

7/22/2019