Endoscopic Services, P.A.
1431 S. Bluffview, Suite 215 • Wichita, KS 67218-3000
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AUTHORIZATION FOR PROCEDURES AND/OR TREATMENTS

1. I hereby authorize Dr._____, and/or his/her assistants designated by him/her, to administer treatment(s) as may be necessary, and to perform the following procedure(s) and/or treatment(s):

   _____

   and any additional procedure(s) and/or treatment(s) which are considered therapeutically necessary on the basis of findings during the above stated procedure(s) and/or treatment(s).

2. The potential risks and complications include the possibilities of: infection, hemorrhage, perforation, missed diagnosis, missed lesions, and/or the need for surgical intervention.

3. I understand that the induction of an intravenous lock is for the administration of medications. I understand that all medications and anesthetics involve risks and the possibility of complications, serious injury, and rarely death from both known and unknown causes, and consent to the administration of such medications and anesthesia as necessary.

4. I acknowledge that I have, to the best of my ability, informed my physician or their associates of all known allergies or unusual reactions to medications and anesthetic agents.

5. I understand the procedure will be performed under non-invasive monitored conditions including: electrocardiogram, blood pressure, and blood oxygen saturation.

6. I authorize any tissue or other material which may be removed from my body to be subject to testing and analysis or disposal according to usual practice.

7. I consent to the participation of a medical student, resident, or other healthcare professional in the procedure room for the purpose of medical education providing my identity is protected. For the advancement of medical education and/or research, I consent to photography, videotapes, and descriptive text of the above stated procedure(s) and/or treatment(s), and I understand that my identity will be kept confidential.

8. I consent to have my blood drawn for testing for any blood-borne diseases as deemed appropriate in the event of an exposure of a healthcare provider to my blood or bodily fluid. I realize I will be informed in the event that this occurs, and the Medical Director of this facility will maintain the results in a confidential manner.

9. I certify that I have read this authorization and understand the purpose of the proposed procedure(s) and or treatment(s), the possible risks and complications and advantages, as well as possible alternatives to the proposed procedure(s) and or treatment(s), including no treatment and consent to the above procedure(s).

10. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

11. I understand that no guarantee or assurance has been made to me as to the results which may be obtained.

This authorization is applicable for the above stated procedure(s) and/or treatment(s) as dated below.

TIME_____

SIGNATURE OF PATIENT_____ **DATE**_____

SIGNATURE OF WITNESS_____ **DATE**_____

SIGNATURE OF WITNESS_____ **DATE**_____