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INFORMED CONSENT FOR GASTROINTESTINAL PROCEDURES

****PLEASE READ THIS DOCUMENT CAREFULLY****
You will be asked to acknowledge your understanding electronically when you arrive for your procedure.

THE PROCEDURE

I hereby authorize Hudson Valley Gastroenterology, PC (HVG), its physicians, technical assistants and other health care providers to perform the following procedure(s) upon me:

Colonoscopy
Sigmoidoscopy
Hemorrhoidal Banding
G-Tube Removal/Replacement
Esophagogastroduodenoscopy (EGD)
Small Bowel Capsule Endoscopy
Dilation

BENEFITS

The information obtained from these procedures will help my doctors in the diagnosis and treatment of conditions of the GI tract that I may have. Finding may help to confirm, assess or exclude a diagnosis or explain the cause of pain, heartburn, diarrhea or other symptoms I may have. Colonoscopy is the best way to screen for colon polyps and colon cancer. The removal of colon polyps may reduce the risk of colon cancer. WATS biopsy is an advanced diagnostic platform that can help detect precancerous cells before they develop into esophageal cancer. Biopsies or removal of polyps may be performed during the examination.

RISKS AND DISCOMFORTS

Just as there may be risks and hazards in not screening for preventable health conditions, there are also potential risks and hazards related to the performance of surgical, medical and/or diagnostic procedures planned for me. I have been informed that common to surgical, medical, and/or diagnostic procedures, possible complications include perforation or bleeding from the bowel which might necessitate additional surgery or hospitalization to repair. Less common

complications reported include infection, phlebitis, paid, blood clots in veins and lungs, aspiration pneumonia, and rarely death. In addition, a polyp or tumor may not always be detected or found.

ALTERNATIVES

Alternatives to colonoscopy/EGD include: no diagnostic testing, non-invasive screening (e.g., Cologuard), barium X-ray studies, and CT colonography. These alternatives are not appropriate or recommended for me at this time but may be recommended subsequently for diagnosis or treatment of GI tract conditions. Exploratory surgery as an alternative to colonoscopy or upper endoscopy carries considerably higher risk.

PATIENT RESPONSIBILITIES

I am aware that information I possess about my general health status and any GI tract abnormalities may affect the safety or accuracy of the procedures to be performed. I acknowledge that I have fully disclosed my medical history and have reported and will report all symptoms that I have and may experience(d) before, during and after the procedure. I further acknowledge that I have reported to the physician performing the procedure and all staff all medications (including all non-prescription drugs, medicinal or dietary supplements) which I have taken recently including the day of the procedure.

CONFIDENTIALITY

I understand that all health information about me will be deemed confidential protected health information and will be subject to HVG's Privacy Practices, a copy of which was provided to me or otherwise made available to me to review.

CONSENT

I understand that my physician may discover other or different conditions which may require additional or different procedures other than those specifically planned. I hereby consent to undergo those procedures if my physician deems them to be in my best interest at the time of discovery. I authorize the taking and publication of photographs in the course of the procedure for the purpose of advancing medical education, provided my identity is protected. I authorize the admittance of authorized medical observers to the procedure suite during my procedure for the purpose of representing new products and acting as a resource. I understand that the observer(s) will in no way participate in the procedure and the supervision of the observer(s) shall be the physician's sole responsibility. I understand and agree that the nature and purpose of the procedure, possible alternative methods of treatment, risks involved, and the possibility of complications have been fully explained to me. I have had the opportunity to discuss this procedure with the doctor who will perform the procedure, and all my questions have been answered to my satisfaction.

I understand and agree that if I have an Advance Directive, that it will be temporarily suspended during and immediately following an office-based procedure while I am under the care of HVG and its staff. Advance Directives for a hospital-based procedure will be managed according to that hospital's policies. I have been advised and understand that admission to a hospital may be in my best interest after a procedure if certain findings or complications arise. If such unforeseen conditions arise during the course of my procedure that my physician determines will require additional procedures, operations or anesthesia, I request and authorize my physician to do whatever he deems advisable and in my best interest. I acknowledge that no guarantees or assurances have been made to me regarding the results of these procedures.

I acknowledge and confirm that I have been verbally informed about the procedure(s) and anesthesia. I have read and understand the contents of this document. I understand the risks and alternatives involved in these procedure(s). I have been given the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I understand that I will receive medication that will alter my perception and coordination. I understand and acknowledge that I will have a responsible adult to accompany me after the procedure and that I will be unable to drive an automobile or operate equipment for 24 hours after my procedure. I consent to the procedures as proposed by my physician.

****I acknowledge that I have read this document in its entirety or had it read to me and will sign this document electronically in the office at the time of my procedure.****

Patient Signature_____**Date**_____ **Time**_____

Witness Signature _____**Date**_____**Time**_____

Provider Certification: I hereby certify that I have explained the nature, purpose, benefits, risks or and alternatives to the proposed anesthesia associated with the procedure to be performed, have offered to answer any questions and have fully answered all such questions. I believe that the Patient/relative/guardian/proxy fully understands what I have explained and answered. I have reviewed the above consent form and hereby confirm the accuracy of the document including the description of the administration of anesthesia.

Provider Signature_____**Date**_____**Time** _____