

HUNT VALLEY ANESTHESIA ASSOCIATES
(Providing Anesthesia Services for Maryland Endoscopy Center, L.L.C.)

Consent for Anesthesia Services

I authorize the Anesthesia Provider, Dr. _____, to provide anesthesia services as part of my upcoming surgery or procedure.

Additionally, I authorize the performance of any other procedures that in the judgment of the Anesthesia Provider may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the surgery or procedure.

I am satisfied with my understanding of the nature of the anesthesia plan of care and the more common risks and complications associated with it. These may include, but are not limited to: swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to blood vessels; nerve damage; allergic reactions to the anesthetic agents; memory dysfunction/memory loss; nausea and vomiting; dental trauma; and prolonged recovery from anesthesia. There is also a rare potential for serious harm, including difficulty breathing, permanent organ damage, cardiac arrest and death.

No warranty or guarantee has been made as to the outcome of the anesthesia plan of care.

I have been given the opportunity to ask questions about the anesthesia. I have been given an explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives. I understand that there are risks with any surgery or procedure, and it is impossible for the physician to inform me of every possible complication. I believe that I have sufficient information to give this informed consent.

In the event my physician, anesthesia provider, or staff is exposed to my blood, body fluids, or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

The undersigned certifies that he/she has read the foregoing, and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

Patient /Authorized Representative Signature

Date/Time

Anesthesia Provider Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the anesthesia and have allowed the patient/responsible adult to ask questions.

Anesthesia Provider Signature

Date/Time