

Middlesex Digestive Health & Endoscopy Center

45A Discovery Way Acton, MA 01720-4482

Patient Name:
MRN:
DOB:
Gender:
Date:
Physician:
Procedure:

Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic and Use and Disclosure of Protected Health Information

Consent to Test for Blood-Borne Diseases

I understand that it may be necessary to test my blood while I am a patient at this Center, in an effort to protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome. If, for example, a Center employee is stuck by a needle after giving an injection, starting an intravenous needle, or drawing blood, I understand that my blood along with the employee's blood will be tested. I have been informed that the performance and results of the HIV antibody test are considered confidential. That the test results in my health record shall not be released without my written permission, except to the individuals and organizations that have been given access by law who are required to keep my health record information confidential.

Consent to Resuscitation

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment (including resuscitative services). The right of self-determination may be effectuated by an advance directive.

Tissue Disposal

I hereby authorize the pathologist to use his/her discretion in the disposal of any tissue removed from me during the procedure or procedure described above.

Consent to Transfer

I understand that the procedure to be performed on me at this Center, will be done on an outpatient basis and that the facility does not provide for 24-hour patient care. If my attending physician, or any other duly qualified physician in his/her absence, shall find it necessary or advisable may transfer me from the facility to a hospital or other health care facility. I consent and authorize the employees of the facility to arrange for and affect the transfer.

Patient Valuables/Personal Property

I understand that the center is not responsible for lost or damaged property such as glasses, contact lenses, hearing aids, dentures, jewelry, coats and/or money.

Payment Obligation

The patient authorizes payment of his/her insurance benefits to the Center. The patient also authorizes payment of any account owed by the patient to this center out of insurance benefits, with any balance of the said benefits to be paid to the order of the patient. The patient understands that he/she is financially responsible to the Center for charges not covered by any insurance company or any other Third Party. Patient hereby specifically agrees to pay to this center the patients' outstanding balance at the time of discharge and in accordance with the terms and rates then in effect. The undersigned also acknowledges that they are jointly and separately liable for any and all amounts due and owing as a result of the care rendered by the Center on behalf of the patient. I/We, the undersigned, agree to pay the cost of collection including a reasonable attorney's fee if this account should be placed in the hands of an attorney for collection suit or otherwise.

Consent to Use and Disclosure of Protected Health Information

My protected health information will be used by the center or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care procedures of the center. I have had the opportunity of reviewing the Notice of Privacy Practices for a more complete description of how my protected health information may be used or disclosed, and I have reviewed the notice prior to signing this consent. I understand that I may request a restriction on the use or disclosure of my protected health information. The Center may or may not agree to restrict the use or disclosure of my protected health information. If the Center agrees to my request, the restriction will be binding on the center. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. I may revoke this consent to the use and disclosure of my protected health information. I must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected. The center reserves the right to modify the privacy practices outlined in this notice. I have reviewed this consent form and give my permission to the Center to use and disclose my health information in accordance with it.

Photography Consent

I consent to the photographing and/or videos of the procedure for medical, educational, or scientific purposes, providing my identity is not revealed by the pictures or descriptive text accompanying them.

Observer Consent

I consent to an observer in the procedure room for medical, scientific, or educational purposes, provided my identity is not revealed to the observer.

Advance Directives

Upon registration, we will ask if you have an advance directive. An advance directive is a written document, which communicates your health care wishes clearly. A copy of your advance directive must be placed in your medical record. There are two types of advance directives:

A Durable Power of Attorney for Health Care

Is a document that allows you to designate another person (known as a proxy agent), who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdraw of life prolonging procedures.

A Living Will or Health Care Directive

Is a document that allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

We acknowledge your directives, however in this facility we do everything in our power to revive patients and thus will not be able to honor your advanced directive.

Certification

The undersigned certifies that he/she has read and understood the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this agreement and consent to and accept its terms. The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information.

Following the procedure, if sedation was administered I will have a responsible person drive me home and I have made arrangements for this. I realize that impairment of full mental alertness may persist for several hours following the administration of sedation and I will avoid making decisions or taking part in activities, which depend upon full concentration or judgment during that period.

Written instructions will be explained and a copy given to me prior to discharge.

I have reviewed this Admission Agreement.

Patient Signature: _____ Date/Time: _____

Patient Name: _____

Witness Signature: _____ Date/Time: _____

Witness Name: _____

Consent for Procedure:

I authorize and direct my physician, _____ to perform the following procedure(s)

_____ COLONOSCOPY _____ UPPER GI ENDOSCOPY _____ OTHER: _____

and /or such other procedure(s) or any other therapeutic procedure(s) which may deem necessary or advisable. Including, but not limited to, the performance of services involving pathology. Upon my authorization and consent such procedure or special diagnostic or therapeutic procedures will be performed for myself by my physician(s) and/or any other physician or qualified persons selected by them.

I understand the nature of the procedure, the expected benefits or effects of such procedure, the medically acceptable alternative procedures or treatments, and that these procedures and special diagnostic or therapeutic procedures all may involve calculated risks or complications including but not limited to bleeding, infection, perforation, splenic injury, missed lesion, organ failure, brain injury or even death. I have a general understanding of the procedure to be performed on me and that no warrantee or guarantee has been made as to the result or cure.

Consent for Medication:

I have been informed by _____ MD of the following types of anesthesia that may be used:

Propofol, IV conscious sedation

Significant risks and complications of the anesthesia to be administered have been explained to me by the anesthesiologist/CRNA/gastroenterologist and include but are not limited to: nausea/vomiting, upper respiratory infection, bronchitis, pneumonia, chipped teeth, cardiac arrhythmia, cardiac arrest, organ failure, respiratory arrest, brain injury and/or death. I accept these risks and hereby consent to the administration of anesthetics. No warranty or guarantee has been made as to the results thereof and I may remember the actual procedure.

Patient Signature: _____ Date/Time: _____

Patient Name: _____

The risks, possible complications, and alternative treatments have been discussed with the patient and the patient has made the decision to consent to the procedure.

Physician Signature: _____ Date/Time: _____

Physician Name: _____