SUMMIT
SURGICAL CENTER, LLC

Consent to Colonoscopy Procedure

1. I, _____ authorize Dr. _____, or his/her associates and such residents/assistants as may be selected by him/her to perform upon me (or the above named patient) the following procedure(s)

Colonoscopy: Pass a flexible tube into the colon to look, biopsy and remove polyp, if necessary. Complications can include perforation, abdominal pain, bleeding, breathing dificulties, side effects of medicines used, failure to complete the procedure.

2. I understand that during the course of the procedure(s), unforeseen circumstances may develop, which may require an extension or modification of the original procedure(s) or a different procedure(s) from that described above. I hereby authorize my physician, his/her associates, or residents/assistants to perform such surgery as they may deem necessary and advisable. This authority shall extend to the performance of procedure(s) for conditions which are not known to my physician at the time the operative procedure(s) is commenced.

3. My physician has adequately explained to me the medically significant risks and likely complications that are or may be associated with this procedure(s), the benefits, the alternatives, if any, and probable results if the condition remains untreated. I have had the opportunity to fully discuss these matters with my physician and have had the opportunity to ask questions I might have. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me about the results of this procedure.

4. During the course of this procedure(s), I further consent to the administration of blood/derivatives if determined by my physician to be necessary and advisable. I have been adequately informed about the risks/complications attendant to the present use of blood/derivatives and the alternatives, if any.

5. Should a bloodborne exposure occur during the procedure, I consent to the drawing of blood for HIV testing. The results of this test will be placed in my medical record and protected in accordance with the applicable laws.

6. I authorize Summit Surgical Center to dispose of any severed tissue, organs, or parts in accordance with their policy.

7. A vendor representative may be present in the Procedure/Treatment Room. The role of the vendor representative is to serve as a resource to the physician and/or nurse regarding equipment to be used.

8. I authorize my physician to photograph and/or videotape my procedure/treatment for purposes of medical documentation and/or medical education. These pictures (without any other identification such as name) may be used for resident training, published in journals or used for any medical care or medical education, or knowledge in general. I understand that I will receive no compensation from Summit Surgical Center or my physician. I understand that I may refuse to allow such physician. I understand that I may refuse to allow such photographing/videotaping without any consequence.

9. I certify that I have read and fully understand this consent form, which has been preceded by an explanation from my physician. I acknowledge and am satisfied that I have been adequately informed concerning medically significant risks, possible complications, the benefits, the alternatives, if any, of this procedure(s) including the likely outcome if this procedure(s) is not done, and specifically consent to such.

This consent is valid for 180 days from the date of the signature unless otherwise specified or revoked by me.

Patient's Signature	Date/Time	Validation of Signature

In the event the above named patient is an unemancipated minor, or is unable to sign for the following reasons:
(i.e.: medical emergency, patient unconscious, incompetent, etc.)

_____

_____

the above consent is given on behalf of the patient by:

Signature of Parent or Representative	Date/Time	Validation of Signature

ATTESTATION STATEMENT:

The above referenced patient has been provided with an explanation of the material risks and likely complications that are or may be associated with this treatment/procedure/intravenous sedation/analgesia, benefits, alternatives, if any, including the likely outcome of not having the procedure(s).

Physician Signature	Date