THE ENDOSCOPY CENTER AT GATEWAY

Procedure Consent

I acknowledge and understand that the above procedure(s) which has (have) been described to me is (are) to be performed on the patient at the Gateway Surgery Center (the "Facility"): I authorize to perform the above operation and/or diagnostic procedure and / or such other operation (s) or any other therapeutic procedure (s) which; may deem necessary or advisable, including, but not limited to, the performance of services involving pathology and radiology. Upon your authorization and consent your physicians and surgeons and / or any other physician and surgeon or qualified persons selected by them will perform such operation or special diagnostic or therapeutic procedures for you. The decision to perform is an ASF vs hospital with the possibility of being transferred to an inpatient facility have been explained to me. I have also been informed of the risks and consequences if no treatment is rendered.

(A) Possible Complications of the Procedure(s):
I understand the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, the medically acceptable alternative procedures or treatments, and these surgical operations and special diagnostic or therapeutic procedures all may involve calculated risks or complications, bleeding, reaction to medication, infection, injury or even death. I have a general understanding of the operation or procedure to be performed on me and that no warranty or guarantee has been made as to the result or cure.

(B) Consent for the Administration of Anesthesia:
I consent to the administration Monitored Anesthesia Care with Sedation as required for the surgery. I understand that anesthesia, separate and apart from the surgical risks, has the potential risks of adverse events and complications such as: Unconscious state, depressed cardiovascular or respiratory status. I understand these risks are always present during light sedation. Following surgery, if IV sedation were 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 conscious sedation and I will avoid making decisions or taking part in activities, which depend upon full concentration or judgment during that period. I have reviewed this Admission Agreement, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic.

(C) Pregnancy Testing: If the Patient is female and unless I opt out below, I request and consent to the Facility performing a urine pregnancy test, as part of the Facility's routine pre-operative lab work due to the possible risks of anesthesia and certain medications on an unborn fetus, including birth defects and miscarriage. I understand a urine pregnancy test is generally accurate, but no pregnancy test is 100% reliable, and there is a possibility this test could miss an early pregnancy or have a false positive result. If the Patient believes she might be pregnant, it is her responsibility to notify her attending physician and anesthesiologist before any medication or anesthesia is given.

(D) Human Immunodeficiency Virus (HIV) and Hepatitis Testing: I understand that in the event a health care worker sustains a significant exposure to my blood or body fluids, I may be asked to undergo testing for HIV, the virus that causes AIDS, and / or hepatitis. The results of any test will be confidential and will be treated in accordance with Pennsylvania law. I understand that, in accordance with Pennsylvania law, a positive HIV test result will be reported to the county health department with sufficient information to identify me. Furthermore, I hereby authorize the Gateway Surgery Center and/or my physician or other health care provider to disclose such HIV test results to any third party payor, as appropriate for processing and payment.

(E) DNR (Do Not Resuscitate) Order:
If I have consented to a do not resuscitate order ("DNR"), I UNDERSTAND AND ACKNOWLEDGE THAT my consent to a DNR order is temporarily suspended/canceled while I undergo any elective, invasive, interventional and/or operative procedure performed at this Facility. I WILL BE RESUSCITATED. This temporary suspension (cancellation) of a DNR order will remain in effect until I am discharged from the facility or transferred to a higher level of care.

(F) Use/Disposal of Tissue: I hereby authorize the Facility to retain, photograph, preserve, and use for scientific or teaching purposes, or dispose of at its convenience any specimens or tissues taken from my body during my procedure or treatment. Specimens or tissues removed may be sent to a laboratory for further testing or examination by a pathologist.

(G) Consent to Transfer: I understand that the surgical and/or diagnostic procedure to be performed on me at the facility 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 to 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 affect the transfer.

(H) Payment Obligation: The patient authorizes payment of his/her insurance benefits to the Gateway Surgery Center. The patient also authorizes payment of any account owed by the patient to Gateway Surgery 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 finically responsible to the center for charges not covered by any insurance company or any other third party. Patient hereby specifically agrees to pay to Gateway Surgery Center the patient's 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 Gateway Surgery 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 collections suit or otherwise.

(I) Observation Consent: For medical, scientific or educational purposes, I consent to the admittance of approved observers to the operating room and release of Gateway Surgery Center and the attending physician from any liability that may arise from their presence in the operating room.

(J) Photographs: I consent to the taking of any photographs in the course of this operation for the purpose of treatment and/or medical education.

(K) No Guarantees: I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

(L) Certification and Signatures:
I certify that I understand the information regarding my procedure and that I have been fully informed of the risks and possible complications thereof, as well as, medically acceptable alternatives to my procedure. I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner. I hereby authorize and permit the physician and whomever he/she may designate as his/her assistants to perform upon me the named procedure(s). Following surgery, if IV sedation were administrated I will have a responsible person drive me home and I have made arrangements for this. I realize the impairment of full mental alertness may persist for several hours following the administration of conscious sedation and I will avoid making decisions or taking part in activities, which depend upon full concentration or judgment during that period.

I have received this admission, Authorization for and Consent to Diagnostic or Therapeutic Procedures, Administration of Anesthetic.

By signing this consent form, I acknowledge that a patient has a right to have advance directives; however, by having a procedure done at this facility will not honor advance directives during the procedure time. In the event an emergency transfer to the hospital is necessary, patients presenting an Advance Directive to a hospital will go into effect upon admission to a hospital

If any unforeseen condition arises during the procedure calling in his/her judgment for additional procedures or medications, I further request and authorize him/her to do whatever he/she deems advisable.