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The state-of-the-art procedure center supporting several regional clinics.

The Center for Digestive Wellness | 10461 Wallace Alley Dr. | Kingsport TN 37663 | ph 423.279.1400 | fx 423.279.1410

Do you have a living will or durable power of attorney (advance directive)? yes no

In the ambulatory 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. Therefore, in accordance with Federal and State law, the facility is notifying you we will not honor previously signed advance directives for any patient.

If you should be transferred to another health care facility upon leaving our Center, your advance directive will be honored according to the policy of that facility.

I certify that I understand the above information regarding gastrointestinal endoscopy and that I have been fully informed of the risk and possible complications thereof. I hereby authorize and permit

M.D. and whomever he may designate as his assistants to perform upon me the following procedure:

The Center for Digestive Wellness is a teaching facility; medical education is part of the facility's role. For the purpose of advancing medical education, I consent to the observation of this procedure(s) by qualified observers (including residents, medical and nursing students). I also authorize the Center to take and exhibit photographs for educational purposes, providing that the information of my identity is not revealed.

I give consent for the administration of indicated anesthesia medication, which will be given during any procedure as my physician deems necessary. If any unforeseen conditions arise during this procedure calling for additional operations, or medication (including anesthesia and blood transfusions), I further request and authorize him to do whatever he deems advisable in my interest. I realize that loose teeth, teeth in poor repair, or capped teeth can occasionally be dislodged by endoscopy.

In the event that a nurse or physician should be exposed to my blood through needle stick or other unforeseen incident, I hereby give my permission for my blood to be drawn and tested for HIV, or any other blood borne pathogen that the physician deems necessary to adequately protect me and my care giver.

I do hereby consent to pay any charges incurred related to this procedure. It is my understanding that there is a direct charge for the procedure itself and that there may be a separate sedation charge, consultation fee and/or laboratory charges. In the occurrence that the insurance carrier denies my eligibility or coverage for these services, I will be fully responsible for remittance of all fees. I have read and understand the foregoing information.

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 concerning the results of the procedure.

Signed: _____ (By patient or legally authorized to consent for the patient)

Date: _____ Witnessed by: _____

NOTE: This facility, or physicians, and employees will not be responsible for any personal items lost during your visit here for your procedure or treatment (jewelry, dentures, glasses, contact lenses, hearing aids, purses, clothing, etc.).

Providing you with the quality care we expect for our own family.