DOCTORS OUTPATIENT CENTER FOR SURGERY

Financial Disclosure Form

"I acknowledge that my physician may have a financial interest in this facility and/ or a product related to my procedure. This Financial relationship may be related to the development of a product or implant or acting as a consultant for such company providing a product or implant related to my procedure. Additionally, I acknowledge that referral to this facility may be related to a financial relationship by the referring physician and/or the physician performing my procedure today."

Dr. Khawar Siddique, Dr. Brian Perri, Dr. Jason Snibbe, Dr. Roy Nini, and Dr. Edward Nomoto.

_____/_____ _____

Patient Name: Print and Signature Date

DOCTORS OUTPATIENT CENTER FOR SURGERY

8436 W. 3RD Street; Suite 700 Beverly Hills, CA 90048 Tel: (310) 274-8228 Fax: (310) 274-8248

Assignment of benefits and Grant of Lien

1. I,_____ , am the person receiving medical treatment from Doctors Outpatient Center for Surgery (DOCS). In consideration of facility, medical and/or anesthesiology services provided to me, or my dependent, I hereby acknowledge and agree that I am responsible for providing compensation for the services provided.

2. If this is a worker's compensation (or other civil) matter, and services are being rendered on a lien or not a lien basis, then I consent to the filing of a lien against my Worker's Compensation (or other civil) case. I understand that I will be solely responsible for payment for the services rendered should my worker's compensation (or other civil) matter be dismissed without a finding that my worker's compensation (or other personal) injury actually occurred. I understand that I will be solely responsible for payment for the services rendered should a judge find that my allegation of injury is not recoverable or otherwise justifiably denied.

3. I have provided Surgery Center with a valid insurance card with an existing insurance company that provides me with medical coverage. I hereby authorize any benefits due to me under this policy to be paid in accordance with this assignment directly to Surgery Center. In consideration of facility, medical and/or anesthesiology services rendered to me or my dependents, I hereby assign and transfer any benefits due to me under the above described medical insurance contract as follows insofar as they are necessary to cover the expense.

4. I understand that, as a courtesy, the Surgery Center will file my primary insurance. After 60 days for the date of surgery, the total balance will be considered due and payable.

5. A photo static copy of this assignment shall be considered effective and valid as the original.

6. In consideration of the services to be rendered, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF SURGERY CENTER IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF SURGERY CENTER. By signing below I certify that I understand the Surgery Center's regular rates and terms. Should the account be referred to an attorney or licensed collection agency for collection, I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within 60 days from the date of service) shall bear interest at the legal rate.

7. According to this assignment of benefits and allowance of lien, under no circumstances should my insurance company provide me directly with a check for services which I received from Surgery Center. I hereby authorize direct payment to Surgery Center of any insurance benefits otherwise payable to me for this admission at a rate not to exceed the Surgery Center's regular charges. It is agreed that payment to the Surgery Center, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this assignment. I understand that the Surgery Center shall have the right at any time to refuse to admit me or to provide medical care of treatment for me. I certify that I am the patient, or I am duly authorized by the patient as patient's general agent to execute this document and accept its terms.

_____ _____

Patient (PLEASE PRINT NAME) Insurance Policy Holder (PLEASE PRINT NAME)

_____ _____

Patient (SIGNATURE) Insurance Policy Holder (SIGNATURE)

Date: _____ Date: _____

ATTACHED PHOTOCOPY OF PATIENT'S (AND INSURANCE POLICY HOLDER'S) IDENTIFICATION AND MEDICAL INSURANCE CARE

_____ Initials of office personnel who witnessed above signatures

Authorized Person Consent Form

Date: _____

RE: Patient Name: _____

Date(s) of Service: _____

To Whom It May Concern,

I, _____(patient) received medical services on _____(date(s) of service. I am giving authorization to speak with: _____ (guardian, spouse or other) concerning **"BILLING"** for the above referenced date(s) of service.

My signature below services as a formal request and authorization for the above stated. I understand my signature will be compared with my original records signed. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature:_____Date:_____
(if patient is a minor, guardian must sign below)

Guardian Signature:_____Date:_____
(authorized guardian if patient is a minor only)

Please send completed form directly to the billing department VIA:

Fax (949) 767-5764

OR

E-mail: docsbilling@gmail.com

DOCTORS OUTPATIENT CENTER FOR SURGERY

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CONDITION OF ADMISSION

1. NURSING CARE

This center provides only general duty nursing care unless upon orders of the patient's physician the patient is provided more intensive nursing care. If the patient's condition is such as to need the ser ice of a special duty nurse it is agreed that such must be arranged by the patient or his/her legal represen tative. The center shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

2. MEDICAL AND SURGICAL CONSENT

The patient is under the care and supervision of his/her attending physician and it is the responsibility of the center and its nursing, staff to carry out the instructions of such physician; the undersigned recognizes that all physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, and the, like, are independent contractors and are not employees or agents of the center. The undersigned consents to X-ray examination, laboratory procedures , anesthesia, medical, or surgical treatment, or center services rendered the patient under the general and special instructions of the physician.

3. RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, the center may disclose portions of the patient' record including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the center's charge, including but not limited to insurance companies health care service plan or worker's compensation carriers.

4. PERSONAL VALUABLES

It is understood and agreed that the center maintains a safe for the safekeeping of money and valuables and that the center shall not be liable for the damage to any money, jewelry, documents, furs, fur coats, and fur garments or other articles of unusual value and small compass, unless placed therein, and hall not be liable for loss or damage to any other personal property, unless deposited with the center for safekeeping.

5. FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself7herselfto pay the account of the center in accordance with the regular rates and term of the center. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts shall bear interest at the legal rate.

6. ASSIGNMENT OF INSURANCE BENEFITS

The W1dersigned authorize whether he/she sign as agent or as patient, direct payment to the center or any insurance benefits or Unemployment Compensation Disability otherwise pa able to the undersigned for this hospitalization at a rate not to exceed the center's regular charge. It is agreed that payment to the center pursuant to this authorization, by an insurance company shall discharge aid insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charge not covered by this assignment.

7. HEALTH CARE SERVICE PLANS

This center maintains a list of the health care service plans with which it has contracted. A list of such plan is available upon request from the financial office. The center has no contract express or implied with any plan that does not appear on the list. The undersigned agrees that he/ he is individually obligated to pay the full cost of all services rendered to him/her by the center if he/she belongs to a plan which do not appear on the above-mentioned list.

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof, and as the patient, is duly authorized by the patient as patient's general agent to execute the above and accept its terms.

_____ _____

DATE PATIENT/PARENT/GUARDIAN

_____ (If other than patient, indicate relationships_____

TIME purpose of Financial Agreement, Assignment of Insurance Benefits Health Care Service Plan, if financial responsibility assumed by other than patient, parent, or legal guardians)

_____

DATE

_____

WITNESS

Policy # 5008

DOCTORS OUTPATIENT CENTER FOR SURGERY

8436 W. 3rd Street, Suite 700 Los Angeles, CA 90048 Tel: (310) 274-8228 Fax: (310) 274-8248

SUBJECT: ADVANCE HEALTH CARE DIRECTIVES

POLICY:

All valid Durable Powers of Attorney for Health Care (DPAHC) and Natural Death Act Declarations remain valid. Unless the patient's existing DPAHC has expired, patient does not have to complete a new ADVANCE HEALTH CARE DIRECTIVE.

A DPAHC executed before 1992 has expired and should be replaced by ADVANCE HEALTH CARE DIRECTIVE.

Because the new ADVANCE HEALTH CARE DIRECTIVE gives patient more flexibility to state the patient's health care desires, patient may wish to complete the new form even if he/she previously completed a DPAHC or Natural Death Act Declaration. At a minimum, patient should review his/her existing DPAHC or Natural Death Act Declaration to make sure it has not expired and that it still accurately reflects patient's wishes.

This policy on ADVANCE HEALTH CARE DIRECTIVES along with other relevant information are provided to patient or patient's representative in advance of the date of the procedure. It's the patient's right to execute or not to execute ADVANCE HEALTH CARE DIRECTIVE. Valid ADVANCE HEALTH CARE DIRECTIVES will be honored.

ADVANCE HEALTH CARE DIRECTIVE is a signed form/document to make sure that the patient's health care wishes are known and considered if for any reason the patient is unable to speak for himself/herself.

Takes effect immediately, but the appointed health care agent is not authorized to make decisions, as long as the patient is able to give informed consent.

An ADVANCE HEALTH CARE DIRECTIVE is valid forever, unless patient revokes it or states in the form a specific date on which patient ants it to expire.

The law prohibits patient from choosing certain people to act as patient's agent(s). Patient may not choose his/her doctor, or a person who operates a community care facility (sometimes called a board and care home) or a residential care facility in which patient receives care. The law also prohibits patient from appointing a person who works for the health facility in which patient is being treated, or the community car or residential care facility in which patient receives care, unless that person is related to patient by blood, marriage, or adoption, or is a co-worker.

Under California law, ADVANCE HEALTH CARE DIRECTIVE allows patient to do either or both of two things:

First, patient may appoint another person to be his/her health care "agent". This person (who may also be known as patient's "attorney-in-fact) will have legal authority to make

decisions about patient s medical care if he/she becomes unable to make these decisions for patient.

Second, patient may write down his/her health care wishes in the ADVANCE HEALTH CARE DIRECTIVE form-for example, a desire not to receive treatment that only prolongs the dying process if patient is terminally ill. Patient's doctor and patient's agent must follow patient's lawful instructions.

Third, ADVANCE HEALTH CARE DIRECTIVE allows patient to express his/her wishes about organ and tissue donation.

Even though patient does not have to appoint a health care agent, the California Medical Association (CMA) recommends that patient does so. Then there will be someone patient trusts to actively participate in the decisions surrounding patient's health care.

The appointed agent should be given a copy of the patient's ADVANCE HEALTH CARE DIRECTIVE so that he/she is aware of the patient's wishes. A copy should be included in the medical record, if at all possible.

Additional information on ADVANCE HEALTH CARE DIRECTIVE is available. If requested, the staff of Beverly Hills Advanced Surgery Institute, Inc. can provide:

1. Introduction to Advance Health Care Directives (California Medical Association)

2. ADVANCE HEALTH CARE DIRECTIVE form

IMPORTANT:

DO YOU CURRENTLY HAVE AN ADVANCE CARE HEALTH CARE DIRECTIVE: Yes ( ) No ( )
IF YES, PLEASE PROVIDE A COPY TO BE FILED IN YOUR MEDICAL RECORD.

IF NO, AND YOU WISH TO EXECUTE AN ADVANCE HEALTH CARE DIRECTIVE, PLEASE REQUEST A COPY OF THE FORM FROM OUR STAFF. THANK YOU.

I HAVE READ AND RECEIVE A COPY OF THIS FACILITY'S POLICY AND INFORMATION ON ADVANCE HEALTH CARE DIRECTIVE:

_____ _____
DATE PATIENT/PARENT/GUARDIAN

_____ (If other than patient, indicate relationship) _____
TIME

DOCTORS OUTPATIENT CENTER FOR SURGERY
8436 W. 3RD Street, Suite 700 Los Angeles, CA 90048 Tel: (310) 274-8228 Fax: (310) 274- 8248

PATIENT'S RIGHTS

IN ACCORDANCE WITH HEALTH AND SAFETY CODES AND HIPAA REGULATIONS, DOCTORS OUTPATIENT CENTER FOR SURGERY (DOCS) AND ITS STAFF HAVE ADOPTED PATIENT RIGHTS INCLUDING, BUT NOT LIMITED TO THE RIGHI' TO:

1. Exercise these rights without regard to sex or cultural, economic, education or religious background or the source of payment for your care.

2. Considerate and respectful care.

3. Knowledge of the name of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians who will see this patient.

4. Receive information from his/her physician about his/her illness, his/her course of treatment, and his/her prospects for recovery in easy to understand terminology. .

5. Receive as much information about any proposed treatment or procedure as ·he/she' may' need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved and knowledge of the name of the person who will carry out the procedure treatment."· -·

6. Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.

7. Full consideration of privacy concerning his/her medical car-e program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to know the reason for the presence of any individual.

8. Confidential treatment of all communications and records pertaining to his/her care and his/her stay at DOCS. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.

9. Reasonable responses to any reasonable requests he/she may make for services.

10. Patient may leave DOCS even against the advice of his/her physicians.

11. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing care.

12. Be advised if DOCS/ personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in any such research projects.

13. Be informed by his/her physician or a delegate of his/her physician of his/her continuing health care requirements following his/her discharge from DOCS.

14. Know which DOCS rules and policies apply to the patient's conduct while a patient.

15. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

16. For any issues or complaints about your medical care, you may contact DOCS or the Department of Health and Human Services as documented in the Notice of Privacy Practices.

17. Designated visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless:

(a) No visitors are allowed.

(b) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.

(c) The patient has indicated to the health facility staff that the patient no longer wants this person to visit.

18. Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making and to have the method of that the CENTER policy on visitation. At a minimum, the CENTER shall include any person living in the household.

19. This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions up on visitation, including restrictions upon the hours of visitation and number of visitors.

(a) A procedure shall be established whereby patient complaints are forwarded *to* the CENTER administration for appropriate response.

(b) All CENTER personnel shall observe these patients' rights.

PATIENT GRIEVANCES

We encourage all our patients and their families to provide us with feedback, suggestions, comments and/or complaints regarding the services we provide. A patient satisfaction survey is handed to every patient after his/her procedure(s) at the facility. This will give each patient the opportunity to provide positive and/or constructive feedback about the facility.

TO REPORT A COMPLAINT OR GRIEVANCE ABOUT YOUR MEDICAL CARE, YOU MAY CALL OR CONTACT:

DOCTORS OUTPATIENT CENTER FOR SURGERY
Dr. Khawar Siddique MD, Medical Director
8436 W 3RD Street Suite 700, Los Angeles, CA 90048
Telephone: (310) 274-8228

CALIFORNIA DEPARTMENT OF HELATH CARE SERVICES
12820 Crossroad Parkway South, City of Industry, CA
91746 Telephone (888) 452-8609

MEDICARE BENEFICIARY
OMBUDSMAN 1-800-
MEDICARE (1-800-633-4227)
WEB ADDRESS: http://www.medicare.gov/Ombudsman/activities.asp

I HAVE READ AND RECEIVE A COPY OF THIS PATIENT'S RIGHTS AND INFORMATION ON PATIENT GRIEVANCE(S):

_____ _____

DATE PATIENT/PARENT/GUARDIAN

_____ _____

TIME IF OTHER THAN PATIENT, INDICATE RELATIONSHIP

Doctors Outpatient Center for Surgery
PATIENT ACCOMPANIMENT UPON DISCHARGE ADVISEMENT

For patient safety, you are hereby advised that it is the policy of Doctors Outpatient Center for Surgery (DOCS) that all patients who receive medical services, requiring anesthesia, be discharged in the company of an adult friend or family member **"responsible adult sponsor".**
DOCS will make every attempt to accommodate your scheduling needs in order to ensure that you have a responsible adult sponsor to accompany you home following discharge. Please be advised that if you arrive for your scheduled surgery and are not willing or able to provide the name and telephone number of a responsible adult sponsor to accompany you home following surgery, your surgery will be rescheduled to another date.

_____ _____

NAME OF ADULT FAMILY OR FRIEND PRESENT CONTACT NUMBER

PATIENT SELF-ASSESSMENT

☐ **NO KNOWN DRUG OR FOOD ALLERGY** **ALLERGIC TO LATEX**: ☐ **YES/Reaction**: _____ ☐ **NO**

☐ **ALLERGIES/REACTION**: _____

HEIGHT: _____ **WEIGHT**: _____

LIST OF MEDICATION (Including aspirin, natural herb supplements, diet pills).

Medication	Dose	Frequency	Last Taken	Unknown

•

LIST PREVIOUS SURGERIES OR PROCEDURES & DATES (including childhood): _____

_____

HEALTH HISTORY

Health Issue			Explain	Health Issue			Explain
High Blood Pressure	Y	N		Arthritis	Y	N	
Stroke	Y	N		Headache	Y	N	
Smoking	Y	N		Thyroid Disorder	Y	N	
Lung Disease	Y	N		Past Anesthesia Problem	Y	N	
Diabetes	Y	N		Pacemaker	Y	N	
Heart Disease	Y	N		Bleeding Disorder	Y	N	
Mitral Valve Prolapse	Y	N		Seizure Disorder	Y	N	
Liver Disease	Y	N		Glaucoma	Y	N	
Kidney Disease	Y	N		Recent Infection/Cold/Flu	Y	N	
Cancer	Y	N		Possible Pregnancy	Y	N	
HIV	Y	N		Metal Implant or Prosthesis	Y	N	
Hepatitis	Y	N		Other	Y	N	

_____ _____ _____

PATIENT SIGNATURE DATE IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP

PATIENT LABEL

DOCTORS OUTPATIENT CENTER FOR SURGERY

8436 West 3rd Street, Suite 700 Los Angeles, CA 90048 Tel: (310) 274-8118 Fax: (310) 274-8248

PATIENT INFORMATION

TO SEE DR._____

PATIENT NAME: _____ DOB:_____ AGE:_____

PATIENT'S SS#: _____ SEX: _____ MARITAL STATUS: _____

PATIENT'S ADDRESS: _____

PATIENT'S PHONE #: _____ OCCUPATION: _____

PATIENT'S EMPLOYER & ADDRESS: _____

EMPLOYER PHONE #: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ DOB: _____ SPOUSE'S SS#_____

SPOUSE'S ADDRESS: _____ SPOUSE'S PHONE #: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S WORK PHONE #: _____

HOW WERE YOU REFERRED TO US? _____

***INSURANCE INFORMATION* - PLEASE DO NOT FILL OUT OFFICE PERSONNEL ONLY**

RESPONSIBLE PARTY NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ HOME PHONE: _____

RESPONSIBLE PARTY: _____ SS#:_____ DOB:_____ EMPLOYER:_____

PRIMARY INSURANCE:_____GROUP:_____PLAN: _____POLICY #:_____

CLAIMS ADDRESS: _____ PHONE #: _____

SECONDARY INSURANCE: _____ PLAN: _____POLICY #:_____

CLAIMS ADDRESS:_____ PHONE #: _____

IS THIS A WORK RELATED INJURY? ☐ YES ☐ NO DATE OF INJURY: _____

WORKMAN'S COMPENSATION INSURANCE: _____ PHONE: _____

ATTORNEY NAME: _____ PHONE: _____

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION

(PLEASE SIGN AND DATE BOTH)

I HEREBY AUTHORIZE THE ABOVE FACILITY TO RELEASE ANY INFORMATION REGARDING SERVICES BY THE FACILITY AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE CLAIMS

_____ _____

Signature **Date**

I HEREBY AUTHORIZE AND DIRECT PAYMENT CHECK (S) FOR BENEFITS DUE FOR THE SERVICES RENDERED BY THE ABOVE NAMED FACILITY TO BE MADE DIRECTLY TO THE FACILITY. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR THE SERVICES RENDERED.

_____ _____

Signature **Date**

DOCTORS OUTPATIENT CENTER FOR SURGERY

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PATIENT CONSENT FOR ANESTHESIA

I understand that:
I will need anesthesia services for the surgery/procedure(s) to be done on_____, _____
(Date) (Time)

- and that the amount of anesthesia to be used will depend upon the procedure (s) and my physical condition.
- anesthesia is a specialty medical service, which manages patients who are rendered unconscious or with diminished responses to pain and stress during the course of a medical/surgical procedure.
- during the course of the procedure, conditions may require additional or different anesthetic monitoring techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well-being.
- although serious harm or death as a result of anesthesia are uncommon occurrences, these can and do occur in spite of good medical care and are of the risks I must consider in deciding to have a procedure.
- a detailed explanation of anesthesia and its risks are given to me not to produce fear or anxiety, but to comply with the law of the State of California.
- no guarantees have been made by anyone regarding the anesthesia services, which I am agreeing to have.

TYPES OF ANESTHESIA AND DEFINITIONS

A. Monitored Anesthesia Care (MAC)

"Conscious Sedation" The anesthesiologist monitors blood pressure, oxygenation, pulse and mental state and administers sedation and analgesia as needed to blunt pain, but the patient remains responsive to verbal command.

B. General Anesthesia

1. Total Intravenous General Anesthesia- A deeper form of MAC (see above). "Unconscious sedation". Spontaneous respiration maintained. Little/no response to verbal command.
2. Endotracheal Anesthesia- Anesthesia and respiratory gases are passed through a tube places in the trachea (windpipe) via the nose or mouth.
3. Mask Anesthesia- Gases are passed through a mask, which covers the nose and mouth.
4. Laryngeal Mask Anesthesia- Gases are passed through a mask placed behind the tongue that covers the larynx (voice box).

C. Regional Anesthesia

5. Epidural Anesthesia- A small catheter is inserted into the epidural space so the anesthetizing agents may be given to prolong the duration of anesthesia.
6. Spinal Anesthesia - The anesthetic agent is injected into the spinal subarachnoid space to produce loss of sensation.
7. Nerve Block- Local anesthetizing agents are injected into specific areas to inhibit nerve transmission.

D. Local Anesthesia

a. Local Anesthesia- Anesthetizing agents are injected or infiltrated directly into a small area of the body, for example, at the surgical/procedural site.
b. Topical Anesthesia- Surface anesthesia is produced by direct application or anesthetizing agents on skin or muscle members.

1. By signing this form, I am indicating that I understand its contents, agree to its provisions, and consent to the administration of anesthesia during my surgery. I know that I can ask more questions and get more information from my anesthesiologist prior to the surgery. I realize that the practice of anesthesiology is not an exact science and no one has given me any promises or guarantees regarding the results.
2. I understand that while I am receiving anesthesia, conditions may develop which require modifying or extending this consent. I therefore authorize modifications or extensions to this consent which professional judgment may indicate to be necessary under the circumstances.
3. I understand that regardless of the type of anesthesia used there are common foreseeable risks including, but not limited to sore throat and hoarseness, nausea and vomiting, muscle soreness and fatigue. Also, instrumentation in the mouth to maintain an open airway during anesthesia may rarely result in dental damage or damage to the gums or lips. The more serious and extremely rare risks of anesthesia include, but are not limited to, heart damage, stroke, or even death. This is only a partial list of possible complications.
4. I understand that medications or drugs that I am taking may cause complications with anesthesia. Therefore I have informed my anesthesiologist about the nature of any medications or drugs, legal or not which I am taking.

Risks and Complications of anesthesia may include but are not limited to allergic/adverse reaction, aspiration, backache, brain damage, coma, dental injury, headache, inability to reverse the effects of anesthesia, infection, localized swelling and or redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/speech by others, seizures, sore throat, wrong site for injection of anesthesia, and death.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent for anesthesia. I agree to the administration of the anesthesia prescribed for me. I recognize that the alternative to acceptance of anesthesia might be no anesthesia for this procedure.

_____	_____	_____
Date/Time	Patient Name (Please Print) (Parent or guardian required if patient is under 18 years & not an emancipated minor)	Patient's Signature
_____	_____	_____
Date/Time	Anesthesiologist/Physician (Please Print)	Anesthesiologist/Physician Signature
_____	_____	_____
Date/Time	Witness Name (Please Print)	Witness Signature