KBEC

KIPS BAY ENDOSCOPY CENTER, LLC

Patient Instruction Packet

Please read the information in this packet at Least 5 DAYS before your scheduled appointment.

Please complete pages 5-11 and 21 & 22 And bring them with you to your appointment along with your photo identification and insurance card.

Kips Bay Endoscopy Center LLC
535 2nd Avenue
Between 29th& 30th Streets
New York, NY 10016
Telephone: 212 889-5477
Fax: 212 889-0517
www.kipsbayendo.com

ASGE Quality ENDOSCOPY UNIT RECOGNITION PROGRAM

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Table of Contents

The forms listed below are enclosed in this packet and are required for your visit to the Center.

Please fill in the information on Pages 5-11 & 21-22 and bring them with you on the day of your appointment. **(PLEASE DO NOT SIGN THE CONSENT UNTIL YOU ARE IN THE CENTER)**

Welcome Notice

Welcome to Kips Bay Endoscopy Center (KBEC). Our aim is to provide the optimal setting in which your endoscopic procedure can be performed in an efficient, safe and comfortable manner. We take pride in our state-of-the-art endoscopic facility that allows your physician to perform your procedure using the latest equipment and most innovative techniques.

The anesthesiologists on staff at KBEC are carefully selected for their high quality and professional manner and are Board Certified or Board Eligible. The anesthesia department has access to the most effective medications and monitoring equipment to ensure that your procedure proceeds with safety and comfort. KBEC's anesthesia safety record is unparalleled.

The Center is fully staffed with experienced Registered Nurses, Endoscopy Technicians and support staff. Our caring staff is dedicated to treating you with the utmost compassion, dignity and respect.

The Endoscopist**s** who utilize the Center recognize our high quality, efficiency and professionalism. In addition, Endoscopist**s** that perform procedures in our facility are locally and nationally recognized leaders in the fields of Gastroenterology and Surgery, participating in medical education and clinical research, and pioneering innovative endoscopic techniques.

KBEC has enjoyed outstanding physician and patient acceptance since its opening in 2004. KBEC is **licensed** by the New York State Department of Health, **CMS certified and accredited by the** Accreditation Association for Ambulatory Health Care (AAAHC) as a free-standing Ambulatory Surgical Center (ASC) for endoscopic procedures.

KBEC was the first free-standing ASC in New York to receive Center of Excellence recognition and maintains this recognition.

KBEC has set the standard for quality in endoscopic facilities in New York City. We are committed to maintaining these high standards. Further information on KBEC can be found on our website: http://www.kipsbayendo.com.

Thank you.

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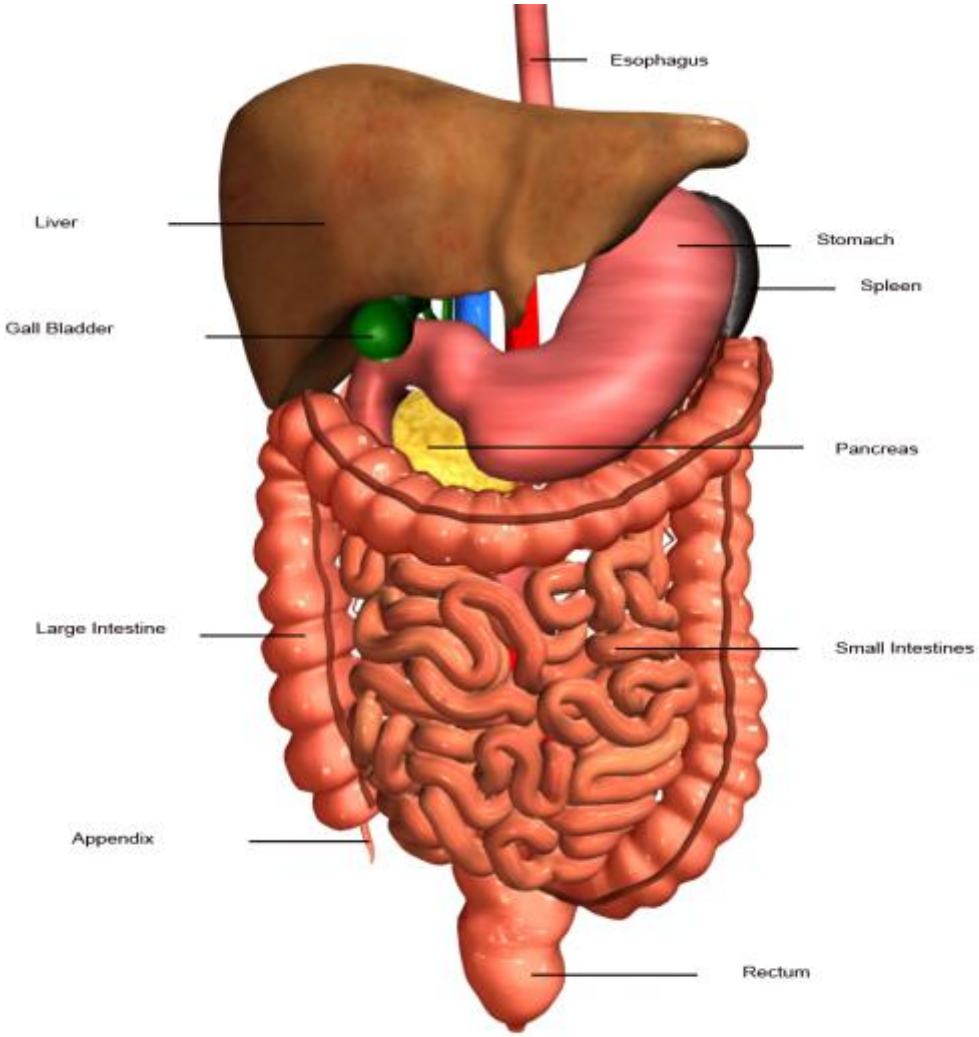
Esophagus
Liver
Stomach
Spleen
Gall Bladder
Pancreas
Large Intestine
Small Intestines
Appendix
Rectum

PATIENT REGISTRATION

(Today's Date) (Date of Birth) (Age) (Gender) (Social Security # or last 4 digits) (Marital Status) **S M W D**

(First Name) (MI) (Last Name)

(Home Address) (Apt#) (City) (State) (Zip Code) (County)

(Home Phone) (Cell Phone) (Alternate Phone) (E-mail Address)

(Name of Spouse/Partner) (Telephone) (Cell Number) (Name of Emergency Contact) (Telephone) (Cell Phone)

(Employer Name) (Address) (City & State) (Zip)

(Occupation) (Work Phone) (Extension) (Fax Number)

For Department of Health Purposes, Please complete the following: Nationality_____ Primary Language _____

Which best describes your race? Circle one: American Indian/Alaskan Native Asian Black or African American Multiracial White

___Native Hawaiian/Pacific Islander ___Declined ___Unavailable/Unknown

Ethnicity - Do you consider yourself Hispanic/Latino? Yes ___ No ___ Declined ___

Name of the person who will escort you upon discharge from the Center **Phone number** **Cell Phone number**

Name of your Primary Care Physician: Address City State Zip Phone Fax

Name of your Referring Physician Address City State Zip Phone Fax

Is there another Physician you want us to send your result to? _____

Do you have any allergies? □ Yes □ No Allergies to Latex? □ Yes □ No Allergies to food? [Please list] _____

Allergies to medications? □ Yes □ No [Please list drug names] _____

Primary Insurance Company Name □ Hosp □ Medical Insurance Phone Number

Primary Insurance Address Group # ID #

Name of Insured Date of Birth Relationship SS #

Secondary Insurance Company Name □ Hosp □ Medical Insurance Phone Number

Secondary Insurance Address Group # ID #

Name of Insured Date of Birth Relationship SS #

I Authorize Kips Bay Endoscopy Center LLC and Kips Bay Anesthesia PC to bill my insurance company for services provided

Signature: _____ Date: _____

Do You Have A Health Care Proxy □ No □ Yes If Yes, Type: _____ Copy Provided? □ No □ Yes

Do You Have A Living Will? □ No □ Yes If Yes, Type: _____ Copy Provided? □ No □ Yes

Patient Signature Date Interpreter's Signature

□ If an interpreter is necessary, please sign above indicating the patient understands and agrees to the terms herein.

PRE PROCEDURE QUESTIONNAIRE/MEDICATION LIST

NAME: _____

DOB:_____ HT: _____ WT:_____

CURRENT MEDICATIONS- Please list all current prescriptions, over-the-counter medications, including MAOI's, vitamins and supplements.

Prescription Medications	Dosage/ Frequency	Date of Last Dose	Prescription Medications	Dosage/ Frequency	Date of Last Dose
			Over-the Counter Vitamins or Herbal Supplement	**Dosage/ Frequency**	**Date of Last Dose**

ALLERGIES: ___Penicillin ___Sulfa ___Aspirin ___Iodine ___Latex ___Soy ___Eggs ___Other _____ **NO ALLERGIES**

If you have allergies, describe reaction(s):_____

MEDICAL HISTORY- Please ☑ all that applies:

❑ Acid Reflux	❑ Chronic sinusitis	❑ Heart Disease	❑Liver Disease	❑ Thyroid Disease
❑ Anemia	❑ Cirrhosis of liver	❑ Heart failure	❑Lupus	❑ Ulcerative Colitis
❑ Arthritis	❑ C-Diff Infection	❑ Heart Murmur	❑Multiple sclerosis	**FAMILY HISTORY**
❑ Asthma	❑ Colon cancer	❑ Hepatitis	❑Pancreatitis	❑Colon Cancer _____
❑ Bleeding disorder	❑ Colon polyps	❑ Hiatal/Groin hernia	❑Parkinson's disease	❑Colon Polyps _____
❑Blood clots	❑ Crohn's Disease	❑ High blood pressure	❑Phlebitis	❑Other Cancers _____
❑Blood Transfusion	❑ Diabetes	❑ HIV or AIDS	❑Polio	Other Information _____
❑Cancer	❑ Diverticulitis	❑ Irregular heart beat	❑Radiation therapy	_____
❑ Chest pain/angina	❑ Emphysema	❑Irritable bowel syndrome	❑Seizures	_____
❑ Chronic anxiety	❑Glaucoma	❑Kidney disease/failure	❑Sleep Apnea	_____
❑Chronic cough	❑ Gout	❑Kidney Infection	❑Stroke/paralysis	
❑Chronic lung disease	❑ Heart attack	❑Kidney Stones	❑TB (Tuberculosis)	

SURGICAL HISTORY- Include all surgeries/procedures and dates. Please be specific._____

_____

_____

Female Patients: **W**hen was your last menstrual cycle? ____/____/_____ Could you be pregnant? ___ No ___Yes

CURRENT MEDICAL CONDITIONS

Do you use oxygen? ___ No ___Yes Are you taking any MAOIs? ___ No ___Yes

Have you taken any prednisone or other steroids for your breathing in the last 3 months? ___ No ___Yes

Have you had pneumonia or bronchitis in the past 6 months? ___ No ___Yes

Past Smoking history ___ No ___Yes If yes, _____ packs/day for _____ years Currently smoking? ___ No ___Yes

Do you drink alcohol? ___ No ___Yes If yes, amount per day: _____

ANESTHESIA HISTORY

Have you ever had anesthesia? ___ No ___Yes

Have you ever had a problem with anesthesia? ___ No ___Yes

Has any member of your family had a problem with anesthesia? ___ No ___Yes

Do you have: Loose/chipped/capped teeth? ___ No ___Yes Do you have Bridges or dentures? ___ No ___Yes

Trouble opening mouth or jaw clicking? ___ No ___Yes

❑ **No** Pre-procedure testing required. ❑ Pre-procedure testing required _____

_____ _____ _____

Reviewing Nurse Print Name Signature Time Date Reviewing Physician Print Name Signature Date

OWNERSHIP DISCLOSURE

Due to concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law, prohibiting the physician, with certain exceptions, from referring you for clinical laboratory pharmacy or imaging services to a facility in which the physician or his/her immediate family members have a financial interest. If any of the exceptions in the law apply, or if he/she is referring you for other than clinical laboratory, pharmacy, or imaging services, he/she can make the referral under one condition. The condition is that he/she disclose this financial interest and tell you about alternative places to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

For more information about alternative providers, please ask your physician, or his/her staff. They will provide you with names and addresses of places best suited to your individual needs that are nearest to your home or place of work.

Statutory authority; *Public health law, §238 a (10)*

The Following Physicians Are The Owners Of The Center:

Owner	Office Address	NPI
John Ackert, MD	232 E. 30TH St. NY, NY 10016	1053335810
Harris Robert Bearnot MD	245 E. 35TH St. NY, NY 10016	1003815952
Jerome Breslaw, MD	235 E. 67TH St. Suite 202 NY, NY 10021	1831106053
Edward Brettholz, MD	232 E. 30TH St. NY, NY 10016	1093739393
Armand Cacciarelli, MD	222 W. 14TH St. NY, NY 10014	1962489880
Jonathan Cohen, MD	232 E. 30TH St. NY, NY 10016	1790709533
Hal Freiman, MD	59 W. 12TH St. NY, NY 10011	1619974953
Charles Friedlander, MD	232 E. 30TH St. NY, NY 10016	1811911670
Inessa Khaykis, MD	232 E. 30TH St. NY, NY 10016	1821204686
Caterina Oneto, MD	232 East 30th St. NY, NY 10016	1245559764
James Salik, MD	232 E. 30TH St. NY, NY 10016	1740204445
Alex Sherman, MD	232 E. 30TH St. NY, NY 10016	1578587283
Charles Silvera, MD	38 E. 32nd St. New York, NY 10016	1245375088
Anthony Starpoli, MD	55 Montgomery St. Poughkeepsie NY 12601	1477633642
Hillel Tobias, MD	232 E. 30TH St. NY, NY 10016	1780608422
Scott Weber, MD	232 E. 30TH St. NY, NY 10016	1871517144

I, _____, confirm that I have read and fully understand the above statements that have been presented/told to me in this document.

_____ _____

Signature Date

Financial Policy

Your physician has chosen to perform your endoscopic procedure(s) at the Kips Bay Endoscopy Center LLC [KBEC]. KBEC is a freestanding Ambulatory Surgical Center [ASC] subject to New York State regulations. It is not associated with your doctor's office and has separate financial and billing policies and procedures.

KBEC will charge you for its facility and anesthesia services. **Please understand that you are responsible for paying your bill(s) in connection with your treatment at the time of registration.** You will also receive a separate bill from your physician for your endoscopy procedure, the anesthesia service and a separate bill for applicable laboratory services. Your physician's, anesthesiologist's and laboratory charges are independent of the KBEC charge.

The following is a statement of our Financial Policy that we require you read and sign prior to your treatment at KBEC.

While your physician may participate in your insurance plan, KBEC may or may not participate with your insurance plan. Prior to the date of your procedure, please verify the details of your insurance coverage with your insurance carrier. To further understand KBEC's policy, please review the following:

1) **If KBEC participates with your insurance plan,** the fees for your services will be billed to your insurance plan. However, you are responsible for the payment of your in-network deductible, co-payments and/or co-insurance at the time of your procedure. These fees are mandated by your insurance carrier and **cannot** be waived. Please contact your insurance carrier to obtain information for the type of benefit you have for an Ambulatory Surgery Center setting. The co-payment amounts differ from that of a physician's office. Please be prepared to pay these fees at the time of your procedure. If you are unable to pay in full at the time of your visit, we expect 50% of your obligation with your insurance and a modest payment plan, not to exceed a year. We accept cash, checks, Visa, MasterCard, Discover, AMEX, or DEBIT cards with a Visa or MasterCard logo. You may also use your Flexible Spending Account (FSA) or Health Savings Account (HSA) to pay your debt.

2) **If KBEC does not participate with your insurance plan,** KBEC will bill your insurance plan. If you have "out-of-network" coverage, your insurance plan may cover a part of this charge. You are responsible for the payment of your deductible and co-insurance as well as any unpaid balance and KBEC will bill you accordingly. If you have no "out-of-network" coverage, you will receive a bill from KBEC for the facility fee and anesthesia fee. You are required to make payment arrangements prior to your procedure. You may also receive a bill for laboratory services if the physician collects biopsy specimen's during the procedure.

3) **KBEC participates with the Medicare program.** If you have Medicare coverage, you will be responsible for payment of the unmet deductible and the remaining 20 percent of the approved charge. Please be prepared to pay these fees at the time of your procedure. We accept cash, checks, Visa, MasterCard, Discover, AMEX, or DEBIT cards with a Visa or MasterCard logo.

4) **Some insurance plans will send KBEC's facility and anesthesia payments directly to you.** If you receive the payments for the services you received at KBEC, you are responsible for forwarding the check directly to KBEC. It is your responsibility to ensure the Center is paid the amount that has been sent to you plus any remaining balance. Be advised that not remitting the payments to KBEC constitutes a breach of contract and KBEC will pursue all legal remedies available to it to obtain such payments.

5) **For private paying patients**, please contact the Center to discuss your payment options.

6) **Return Check Fee.** If you make payment to the Center by check and it is returned by the bank for any reason, you will incur a fee of $30.00.

_____ _____

Signature of Patient or Responsible Party Date

_____, _____

Name of person reviewing this form with patient. (If applicable) Title Date

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

Name: _____ Med. Rec. #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct Kips Bay Endoscopy Center LLC, having treated me, to release governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize Kips Bay Endoscopy Center, LLC, to release medical information in the event of any emergency transfer to an Acute Care Facility.

If I am transferred to or admitted to other institutions in relation to my procedure, I authorize the release of all my medical records pertaining to that transfer or admission to Kips Bay Endoscopy Center, LLC.

_____ _____

Signature of Patient or Authorized Representative Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to Kips Bay Endoscopy Center LLC, sufficient monies and/or benefits to which I may be entitled for government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent.

I, the undersigned, have insurance with _____ and assign benefits directly to the provider for all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Patient or Authorized Representative Date

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER Tile XVIII of The Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment to me.

_____ _____

Signature of Patient or Authorized Representative Date

CONSENT FOR LABORATORY BILLING

During the course of your procedure, it may be necessary for your physician to obtain and send tissue samples, blood samples or request other laboratory testing. New York State requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the Center to receive authorization from the Patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, than billing services will go directly to you as the Patient. Please complete and sign below so that we may direct this issue in the proper manner. Thank you for your cooperation.

[ ] Yes, I am giving the laboratory permission to bill my insurance company

[ ] No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for the payment of services directly to the laboratory.

_____ _____

Signature of Patient or Authorized Representative Date

*The signature of the patient must be obtained unless the patient is an un-emancipated minor under the age of 18 or is otherwise incompetent to sign.

Patient Acknowledgment of Advance Notice

I hereby acknowledge receipt of the Center's HIPAA Notice of Privacy Practices and acknowledge that the Center may use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me and performing routine healthcare operations and services in the Center.

By signing below, I hereby acknowledge that I received written the notice of the Patient's Bill of Rights and Responsibilities prior to the start of my procedure;

I hereby acknowledge that I received a written list of physicians who have financial interest or ownership in the ASC facility;

I hereby acknowledge that I was offered written information concerning Advance Directives;

I understand that I am **required** to bring an escort to take me home on the day of the procedure;

I understand that I may be financially responsible for any outpatient facility charges, as outlined in my insurance coverage for copayments, coinsurance and deductibles.

_____

First Name M.I. Last Name

_____ _____

Signature Date

_____ _____

Witness Date

_____ _____

Interpreter Date

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

The waiver authorizes KIPS BAY ENDOSCOPY CENTER (KBEC) to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information (PHI) on my home /cell phone:
O Yes O No

Leave a voice mail recording including my Personal Health Information on my business phone:
O Yes O No

Use of electronic communication systems (i.e. fax, electronic messaging) to transmit prescription, treatment, disorder related information, lab or other results: O Yes O No

Use of email to transmit treatment or disorder related information which may include a diagnosis, lab or other results sent to me, even if the email is not encrypted (not protected over the Internet):
O Yes O No

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results:
O Yes O No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Heath Information:
O Yes O No

Name of Personal Representative/Relationship _____

On this date_____, I received and reviewed KBEC's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I had an opportunity to raise questions regarding this policy and all of my questions have been answered. The authorizations made above will remain effective until such time as I notify Kips Bay Endoscopy Center, in writing by certified mail, of requested changes.

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Patient or Parent/Guardian Signature Date

_____ _____
Patient's Social Security Number or last 4 digits Email Address

_____
Home Address Telephone Number

PROCEDURE INFORMATION SHEET

An upper endoscopy or **EGD (EsophagoGastroDuodenoscopy)** involves the insertion of a lighted flexible tube, called an upper endoscope, into the mouth. The tube is guided by direct vision into the esophagus, stomach, and duodenum so that the lining of the upper gastrointestinal tract is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. Areas that are bleeding may be cauterized to stop active bleeding or to prevent future bleeding. An EGD is a generally safe procedure but carries several risks that include, but are not limited to, perforation and bleeding. Serious complications of EGD, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

***

A **Colonoscopy** involves the insertion of a lighted flexible tube, called a colonoscope, into the rectum. The tube is inserted so that the lining of the entire colon is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. In addition, growths of the colon, called polyps, may be removed (polypectomy) by the use of an electrified wire, called a snare. A colonoscopy is generally a safe procedure but carries several risks that include, but are not limited to, the following: bleeding from biopsy or polypectomy; perforation or puncture of the colon which would likely require a surgical operation to repair; and, contact colitis; that is, irritation of the lining of the colon from contact with the colonoscope. Serious complications of colonoscopy, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

***

Endoscopic Ultrasound, also known as EUS or Endosonography, is a specialized endoscopic study that enables your doctor to examine your stomach lining and the walls of your upper and lower gastrointestinal tack. EUS is also used to study internal organs next to the intestinal tract such as the Gall Bladder and Pancreas. The procedure is similar to routine endoscopy (EGD) or colonoscopy. A flexible tube is guided visually into the mouth or rectum. Then the EUS is used to scan and obtain ultrasound images. It is also possible to obtain tissue sampling via a fine needle aspirate (FNA) using real time ultrasound guidance.

EUS is generally a safe procedure, but carries several risks that include, but are not limited to, infection, perforation and bleeding. Serious complications of EUS, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

***

Flexible Sigmoidoscopy lets your doctor examine the lining of the rectum and a portion of the colon (large intestine) by inserting a flexible tube about the thickness of your finger into the anus and slowly advancing it into the rectum and lower part of the colon.

***

Risks of the sedative medications include, but are not limited to, allergic reactions and respiratory depression. In addition to the risks described above about this procedure there are risks that may occur with any surgical or medical procedure.

There can be no guarantees regarding the results of this procedure. Although endoscopic procedures are sensitive for the presence of gastrointestinal abnormalities, there is a risk that significant abnormalities of the gastrointestinal tract may not be detected by this procedure; this is especially true if the preparation of the gastrointestinal tract is not ideal.

Further information about these procedures can be obtained at the following organization websites:

The American College of Gastroenterology:

www.acg.gi.org/patients/

The American Society for Gastrointestinal Endoscopy:

www.asge.org

PATIENT ESCORT POLICY

As a matter of patient safety, Kips Bay Endoscopy Center enforces the CMS Conditions for Coverage Section **§416.52(c) Standard: Discharge**.

Quoted:

The ASC must -
(3) Ensure all patients are discharged in the company of a responsible adult.

That is, a companion, family member or friend should accompany you home following your procedure.

If you do not have someone to escort you after the procedure, please contact the Visiting Nurse Services of New York (888 943-8435) to arrange for a care partner to accompany you home from your procedure.

For additional information and to make arrangements for a care partner, you can visit the following website: www.partnersincareny.org. Or e-mail: par_intake@vnsny.org.

Please Note That Your Procedure Cannot Be Performed Unless Your Escort Is Verified.

Thank you for your cooperation.

PERSONAL POSSESSIONS POLICY

Kips Bay Endoscopy Center will provide you with a private locker to safely store your personal belongings during the procedure. We strongly encourage you to use the locker provided.

Please **DO NOT** wear jewelry, **DO NOT** bring laptops, **DO NOT** bring electronic devices, or any other valuables when you come to the Center.

Please note that Kips Bay Endoscopy Center assumes no responsibility for lost, stolen, or misplaced items.

Thank you for your cooperation.

Frequently Asked Questions (FAQ's)

The following list of questions and answers may assist you in preparing for your procedure:

Q) I am having an upper endoscopy. Do I have to do anything to prepare for this procedure?

A) *There is no specific preparation but you should not eat or drink anything after midnight the night before the test.*

Q) I am having a colonoscopy or sigmoidoscopy. Do I have to do anything to prepare for this procedure?

A) *Yes. Please follow your physician's instruction for this procedure. Please contact your physician's office for a prescription or instructions*.

Q) My procedure is scheduled for the afternoon. Can I eat or drink anything the morning of the procedure?

A) *You should not eat anything after midnight. You may have up to 1 cup of clear liquid four hours prior to your scheduled arrival time at KBEC.*

Q) Will my procedure be painful?

A) *No. The Center is fully staffed with Board-certified anesthesiologists to ensure that your procedure is comfortable.*

Q) How long will I be at the Center?

A) *You will be at the Center approximately 2 hours in total. You will spend less time at the center by making certain you are punctual for your appointment. Arriving earlier than your appointment time won't necessarily get you through faster, while arriving late will probably cause you to lose your scheduled time slot and create substantial delays for you. Completing the required paperwork (available on-line or by mail) prior to your arrival, will expedite the process.*

Q) Do I have to bring an escort with me?

A) *Yes. The Center requires that you have an escort to take you home.*

Q) My doctor has all my insurance information. Do I need to bring my insurance card and billing information?

A) *Yes. KBEC is an independent entity and has no connection to your doctor's office.*

Q) Will I receive a bill?

A) *Yes. Co-Payments will be collected at the time of your visit. We will bill your insurance company or HMO directly for the Center's services. Please contact your insurance carrier to obtain information regarding what **your** responsibility is in an Ambulatory Surgery setting and for Anesthesia Services. You will also be billed for your in-network deductible and co-insurance. Your insurance company determines this amount. It is important that you are aware of your out of pocket cost. ***

****Please note that some insurance companies may send payment directly to you for the facility and anesthesia service. We expect that you will forward this payment and any balance directly to KBEC.**

FAQ's (continued): Special Medical Considerations

Q) Do I take my heart medications on the day of my procedure?

A) *In general, you can continue to take prescribed medications before and after gastrointestinal endoscopy without modification. Please take all medications on the morning of your procedure. Medication should be taken with a small amount of clear liquid.* ***Please contact your physician*** *if you are on* ***aspirin, blood thinners and diabetic medications. Your physician will give you specific instructions regarding these medications.*** *If you are unsure if the medications you take fall into these categories, please ask your physician.*

Q) I take aspirin, or anticoagulants or other blood thinners. Do I need to stop these medications before my procedure?

A) I*n general, aspirin, anticoagulants and other blood thinners should be stopped at least 3 days prior to your procedure. This is to reduce the chance of bleeding if biopsies are obtained or polyps are removed.* ***There are, however, important medical circumstances in which these medications must NOT be stopped. If you have any questions about stopping these medications, consult your primary physician.***

Q) I am a diabetic. Should I take my medication on the day of my procedure?

A) *In general, diabetic medication should* ***not*** *be taken on the day of your procedure.* ***There are, however, important medical circumstances in which these medications must not be stopped. If you have any questions about stopping these medications, consult your primary care physician.*** *A finger stick blood sugar will be obtained by the KBEC staff to ensure proper management of your blood sugar during your procedure. When the procedure is over and you have resumed a normal diet, your usual diabetic regimen should be resumed.*

Q) I have been told to take prophylactic antibiotics prior to dental work. Do I need to take antibiotics before my endoscopic procedure?

A) *With rare exceptions, the procedures performed at KBEC do* ***not*** *require the administration of prophylactic antibiotics. If, however, you are advised by your physician to take antibiotics prior to gastrointestinal endoscopy, you may take them orally, 1 hour prior to the procedure, with a small amount of clear fluid. If you are uncertain if you require anti-biotics prior to your GI Endoscopy procedure or if you need a prescription, please call your doctor prior to your appointment.*

Q) What if I am pregnant or may be pregnant – should I undergo gastrointestinal endoscopy?

A) *If you are pregnant, you should consult with your physician about whether you should undergo gastrointestinal endoscopy. If you are a woman of child-bearing age, KBEC will administer a pregnancy test prior to your procedure in order to optimize your management.*

Q) I am breast feeding my baby. Is the procedure safe for my baby?

A) *In general, women who are breast feeding may safely undergo gastrointestinal endoscopy – the administered anesthetic is not excreted in significant quantities in breast milk. Some mothers elect to store milk via a breast pump and feed the child with the pumped milk on the day of the procedure. Normal breast feeding may resume the following day.*

DIRECTIONS TO KIPS BAY ENDOSCOPY CENTER
LOCATED AT 535 2ND AVENUE NYC, NY 10016

Directions by car: www.mapquest.com

From Long Island and Queens

Take I-495 W towards the L I Expressway/Midtown Tunnel Portions toll road.

Take the exit on the left towards 34th Street downtown.

Turn left at E 34th St

Take the 1st right onto 2nd Ave Destination will be on the right

From Brooklyn*:*

Take the exit onto I-278 E toward Bklyn-Qns Expy/Queens/Bronx

Take exit 28B to merge onto Brooklyn Bridge - 1.2 mi

Take the F D R Dr/Pearl St exit - 0.2 mi

Keep right at the fork, follow signs for F.D.R. Dr N and merge onto F D R Dr/E River Dr - 2.6 mi

Take exit 7 toward E20-E23 St - 0.3 mi

Turn right at Avenue C - 0.3 mi

Turn left at FDR Drive Service Rd E - 82 ft.

Continue onto E 23rd St - 0.2 mi

Turn right at 1st Ave - 0.3 mi

Turn left at E 29th St - 0.3 mi

Turn right at the 2nd cross street onto 3rd Ave - 282 ft.

Take the 1st right onto E 30th St - 0.1 mi

Take the 1st right onto 2nd Ave - 128 ft.

From NJ*:* Take exit 16E toward Lincoln Tunnel

Keep left and merge onto NJ-495 E Partial toll road Entering New York

Continue onto NY-495 E - 0.8 mi

Take the exit toward Dyer Ave - 0.2 mi

Turn right at Dyer Ave - 0.1 mi

Turn left at W 34th St - 1.3 mi

Turn right at 2nd Avenue - 0.2 mi

Turn right at 2nd Ave - 0.2 mi

From CT

Take the exit onto I-95 S toward N.Y. City Entering New York

Continue onto I-278 W Take the exit toward FDR Dr

Merge onto Tri-borough/RFK Bridge Portion toll road

Take the FDR Dr South ramp to the 34th Street exit

Directions by Subway & Bus

East Side – Lexington Avenue IRT #6 to 28th Street and Park Ave

West Side – Subway to 42nd Street, Take shuttle to Grand Central Station, then #6 to 28th Street Station

Penn Station – 34th Street Cross-town Bus to 2nd Avenue

Grand Central Station – Lexington Avenue Bus to 30th Street

Parking Information - There is a parking lot on 30th Street between 3rd and 2nd Avenues and another on 29th Street between 1st and 2nd Avenues

Patient Rights & Responsibilities

The patient has the right to:

1. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor.
2. Be treated with consideration, respect and dignity including privacy in treatment.
3. Be informed of the services available and applicable charges at the Center.
4. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care.
5. Be informed of the provisions for after hours and emergency care.
6. Receive an itemized copy of his/her account statement, upon request.
7. Obtain from his/her Health Care Provider, or the Health Care Practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
8. Receive from his/her Physician information necessary to give informed consent prior to the start of any non-emergent procedure or treatment or both.
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.
10. Refuse to participate in experimental treatment.
11. Voice grievances and recommend changes in policies and services to the Center's staff, The Operator and the New York State Department of Health without fear of reprisal.
12. Express complaints about the care and services provided and to have the Center investigate such complaints. If the patient is not satisfied by the Center's response, the patient may complain to the New York State Department of Health's Metropolitan Area Regional Office (MARO) at 800 804-5447.
13. Privacy and confidentiality of all information and records pertaining to the patient's treatment.
14. Approve or refuse the release or disclosure of the contents of his/her medical record to any Health Care Practitioner and/or Health Care Facility except as required by law or third-party payment contract.
15. Access their medical record pursuant to the provisions of the law.
16. To Execute an Advance Directive and/or Health Care Proxy and
17. To receive pain management services.

The patient has the following responsibilities:

1. To provide the Center with complete and accurate information to the best of his/her ability about his/her health, any medications, including over the counter products and dietary supplements and allergies or sensitivities.
2. To ask all questions you may have regarding the treatment provided by the Center.
3. **Provide a responsible adult to transport** him/her home from the facility and if required by his/her provider, remain with him/her for 24 hours.
4. To consent by free will to all procedures.
5. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
6. To tell us if you do not understand procedures or instructions.
7. To follow after-care instructions as recommended by the Center.
8. To contact his/her Physician with post-testing questions or concerns.
9. To provide all necessary information regarding third-party payment sources.
10. Accept personal financial responsibility for any charges not covered by his/her insurance.
11. To observe all the Center's Policies and Regulations.
12. To keep appointments as scheduled, or advise the Center if the appointment cannot be kept.
13. To be considerate of other Patients and Personnel and respect the property of others and the Center.

PATIENT SELF-DETERMINATION ACT/ADVANCE DIRECTIVES

Kips Bay Endoscopy Center supports each patient's right to develop an advance directive; the Center will not condition the provision of care or discriminate against an individual based on whether or not an advance directive has been executed; and will provide education for its staff, patients and the community, as applicable, related to the patient self-determination act/advance directives.

The Center is an Ambulatory Surgical Center for the purpose of performing elective Endoscopy in a safe and uncomplicated manner; patients are expected to have an excellent outcome. The center cannot in good conscience comply with any written decision established in an Advance Directive that would prevent the physicians and/or nursing staff from performing resuscitative measures in the event of a medical emergency. All patients will have resuscitative measures performed in the event of a complication and will be transferred to the nearest hospital in the event of deterioration.

If you are interested you may request resource information regarding self-determination. The information includes:

- The description of state law prepared by the Department of Health entitled, "Deciding About Health Care – A Guide For Patients and Families".
- The pamphlet prepared by the department of health entitled, "Appointing Your Health Care Agent - New York State's Proxy Law".
- A model "New York Living Will".
- The fact sheet entitled, "Deciding About CPR Do Not Resuscitate Orders (DNR)".
- A handout entitled, "Ten Basic Questions And Answers For Consumers On The Patient Self-Determination Act".
- A handout entitled, "Definitions for a Health Care Proxy".

Our staff will inquire and document your present status concerning advance directives during the pre-procedure assessment in the medical record.

If you have executed an advance directive and have brought a copy, this copy will be filed in your medical record.

If copies are not immediately available, the types of advance directives and the name and address of the healthcare agent are obtained and documented in your medical record.

If you request additional information or wish to make an advance directive, the Center will supply you with appropriate information and direction.

The Center will comply with the health care decisions made in good faith by a health care agent to the same extent as decisions made by a competent adult.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research

Our Uses and Disclosures

- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you fell your rights are violated

- You can complain for feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, to others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead to share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Notice of Privacy Practices

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities
Examples: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and researcher. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to mediations
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such a military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us you can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.**

Changes to the Terms of Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effect date: January 1, 2015
Privacy Official: Elizabeth Yuen, E-mail eyuen@kipsbayendo.com, 212 889-5477 ext. 119.
Kips Bay Endoscopy Center "We never market or sell personal information."

I, _____ hereby authorize and permit: Dr._____,
Dr. _____ and any associates or assistants including the anesthesiologist that the doctor deems appropriate, to perform upon me the following:

☐ Colonoscopy with or without biopsy/polyp	☐ Upper Endoscopy (EGD) with or without biopsy/polyp	☐ Sigmoidoscopy with or without biopsy
☐ Colon EUS	☐ Upper Endoscopy EUS	☐ Sigmoidoscopy with EUS
☐ Colon with Fecal Transplant	☐ Upper Endoscopy EUS with FNA	☐ Sigmoidoscopy with banding
☐ Other		☐ Enteroscopy

The doctor has explained the benefits of gastrointestinal endoscopy to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s). I am aware that the practice of medicine and surgery are not an exact science. I also authorize the administration of IV sedation as may be deemed advisable or necessary for my comfort, well-being, and safety. I have been informed by my physician and the staff of the Kips Bay Endoscopy Center that if I receive sedation, I should not operate a motor vehicle for twelve hours following the procedure.

Explanation of Procedure

Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal Endoscopy. Your physician has advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures.

At the time of your examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may also be removed.

Brief Description of Endoscopic Procedures with Monitored Anesthesia Care

1. **EGD (Esophagogastroduodenoscopy):** Examination of the esophagus, stomach, and duodenum. If active bleeding is found, coagulation by heat may be performed or clips may be applied.
2. **Endoscopic Ultrasound**, also known as EUS or Endosonography, is a specialized endoscopic study that enables your doctor to examine your stomach lining and the walls of your upper and lower gastrointestinal tract. EUS is also used to study internal organs next to the intestinal tract such as the Gall Bladder and Pancreas.
3. **Dilation:** Dilating tubes or balloons are used to stretch narrow areas of the intestinal tract.
4. **Hemorrhoid Banding:** The physician places a latex (rubber) band around the hemorrhoid to reduce the flow of blood to the vein, thereby preventing further bleeding.
5. **Flexible Sigmoidoscopy:** Examination of the anus, rectum and left side of the colon, to a depth of 60 cm.
6. **Colonoscopy:** Examination of all or a portion of the colon. The procedure may involve collection of a specimen.
7. **Enteroscopy:** Small intestinal Endoscopy beyond the second portion of the duodenum and not including the ileum. The procedure may involve collection of a specimen.
8. **Polypectomy:** Using a wire loop and electric current, polyps (protruding growths) can be removed from the digestive tract; commonly done with colonoscopy and less commonly with EGD.
9. **Monitored Anesthesia Care (MAC):** Administration of IV medications by an anesthesiologist to achieve a state of relaxation sufficient to improve tolerance for the procedure but not intended to result in significant depression of breathing or total inability to respond.

Principal Risks and Complications.

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure ***including, but not limited to*:**

1. **Perforation:** Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required.
2. **Bleeding:** Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation, or may require transfusions or a surgical operation.
3. **Minimal, Moderate to Deep IV Sedation Medication and Pregnancy:** I understand that there are risks involved with IV sedation and to my knowledge, I am not pregnant. If there is a question that I may be pregnant, then I will allow a urine pregnancy test to be performed prior to my procedure. Under this type of anesthesia sedation is produced by injecting medicines into the bloodstream to make me unresponsive, but not unconscious. All types of anesthesia involve some risk. These risks include, but are not limited to allergic or adverse drug reactions, respiratory depression, hypoxia (low blood oxygen), low blood pressure, nausea, vomiting, arrhythmias (disorders of regular rhythmic beating of the heart), and injuries to the vein. Complications from anesthesia are uncommon, but may occur. There is a remote possibility of death as a complication of anesthesia. No guarantee has been made that sedation will eliminate awareness, anxiety, or discomfort.
4. **Medication Phlebitis:** Medications used for sedation may irritate the vein into which they are injected. The irritation may result in a red, painful swelling of the vein and surrounding tissue that can become infected. Discomfort may persist for several weeks or months.

5. **Missed Lesions (Polyps and Cancer):** During your colonoscopy the physician will attempt to identify all polyps and cancer, and remove all polyps if possible. Although colonoscopy is the best test to find and remove these lesions, there is a small chance that one or more may be missed.
6. **Splenic Tear:** As the scope passes through the splenic flexure in the colon, there is the rare possibility that an injury can occur to a patient's spleen. A splenic tear is an abrasion on the spleen that could result in hospitalization, the need for blood transfusion, and may even require surgery to treat.
7. **Other Risks** include, but are not limited to respiratory problems, decrease in blood pressure, allergic reaction, slurred speech, impaired cardiovascular function, aspiration and pneumonia, heart attack, damage to teeth or dental work (when instruments are inserted through the mouth, sore throat, clotting or infection in the vein where medication is given, and very rarely, death. Instrument failure is also extremely rare but remains a remote possibility. Drug reactions and complications from other diseases are possible.

YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS.

In addition, older patients and those with extensive diverticulosis and/or adhesions from previous surgery are more prone to complications. All of the above complications are possible but occur with a very low frequency. Occasionally one or more of these complications could result in transfer to the hospital for hospitalization, blood transfusion, or the need for surgical intervention for correction. Your physician will discuss the frequency of these complications if you desire in reference to your own indications for the endoscopy.

In permitting my doctor to perform gastrointestinal endoscopy, I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his/her assistants (including physicians and or nursing staff) and anesthesiologist perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment. I understand the Endoscopy Center **does not recognize Do Not Resuscitate** orders and will use all measures possible to sustain life.

Alternatives: The reasonable alternative(s) to gastrointestinal endoscopy, as well as the risks to the alternatives, have been explained to me. The alternatives include **but are not limited to** the following. Although gastrointestinal endoscopy is a safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases a failure of diagnosis or a misdiagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

I hereby authorize the doctor to dispose of any removed tissues resulting from the procedure(s) authorized above.

I consent to the taking and publication of photographs or videotapes of the procedure(s) made during my procedure for use in the advancement of medical education, provided my identity is not revealed by the pictures or by descriptive text accompanying them.

Written discharge instructions will be reviewed with me and a copy will be sent home with me. I will read and comply with them.

Any questions I had regarding gastrointestinal endoscopy and IV sedation that apply to my clinical circumstances have been answered to my satisfaction. The advantages and disadvantages of the endoscopy center versus the hospital setting have been discussed with me. I authorize the anesthesiologist of Kips Bay Endoscopy Center and Kips Bay Anesthesia PC to perform Monitored Anesthesia Care (MAC), commonly called IV sedation, and any other anesthetics as may be deemed advisable as a part of my upcoming GI Procedure.

☐ I or my Authorized Individual have read the forms or have it read to him or her.
☐ I or my Authorized Individual expressed understanding of the form.
☐ I or my Authorized Individual have no questions.

CERTIFICATION OF PHYSICIAN

I hereby certify that I have discussed and explained the facts, risks, and the risks associated with the procedure, alternatives of the procedure(s) described in this Consent form with the individual granting consent.

Print Patient/Guardian Name Interpreter if Necessary

Patient Signature Date Time

Physician Name and Signature Date Time

Witness Date Time

CERTIFICATION OF ANESTHESIOLOGIST

I hereby certify that I have discussed and explained the facts, risks, the risks associated with the alternatives of the anesthesia described in this Consent Form with the individual granting consent.

Print Patient/Guardian Name Interpreter if Necessary

Patient Signature Date Time

Physician Name and Signature Date Time

Witness Date Time