SWGA SOUTHWEST GASTROENTEROLOGY ASSOCIATES, PC

7788 JEFFERSON N.E., ALBUQ., N.M. 87109

SEDATION CONSENT

I________________________________ DOB: ____________________

HAVE BEEN ADVISED BY SOUTHWEST GASTROENTEROLOGY ASSOC., P.C. THAT I WILL BE RECEIVING SEDATION FOR MY PROCEDURE ON_______________, AT ____________ WITH DR.________________________________.

I HAVE ALSO BEEN ADVISED THAT I WILL NOT BE ABLE TO OPERATE A VEHICLE FOLLOWING THE PROCEDURE, AND WILL THEREFORE BE RESPONSIBLE FOR OBTAINING A DRIVER. I UNDERSTAND THAT A TAXI OR PUBLIC TRANSPORTATION IS NOT ALLOWED. I AM FULLY AWARE THAT IT MAY BE NECESSARY TO RESCHEDULE MY PROCEDURE, SHOULD I NOT MAKE ARRANGEMENTS FOR SOMEONE TO DRIVE ME HOME. IF YOU HAVE ADVANCE DIRECTIVES PLEASE NOTIFY THE HOSPITAL WHERE YOUR PROCEDURE WILL BE PERFORMED.

YOU CAN EXPECT TO INCUR CHARGES FROM POSSIBLY THREE SOURCES:

- *PHYSICIAN PROFESSIONAL FEE--THROUGH OUR OFFICE*
- *HOSPITAL OR AMBULATORY SURGERY CENTER FEE (SOUTHWEST ENDOSCOPY) WHERE PROCEDURE IS PERFORMED*
- *PATHOLOGY—THROUGH THE LAB USED TO EXAMINE BIOPSY SPECIMENS, IF ANY ARE OBTAINED*

PLEASE BE PREPARED TO PAY YOUR CO-PAY, CO-INSURANCE, OR DEDUCTIBLE ON THE DAY OF YOUR PROCEDURE. WE WILL FILE THE PHYSICIAN AND HOSPITAL CHARGES WITH YOUR INSURANCE COMPANY. WE ENCOURAGE YOU TO SPEAK WITH OUR BILLING OFFICE SHOULD YOU HAVE ANY QUESTIONS OR CONCERNS. I ACKNOWLEDGE AND ASSUME RESPONSIBILITY FOR ALL CHARGES INCURRED AND FOR PAYMENT OF SERVICES AT THE TIME RENDERED.

SIGNATURE X ____________________________ DATE __________________

WITNESS __________________________________ DATE __________________