GASTROENTEROLOGY DIAGNOSTICS OF NORTHERN NEW JERSEY, P.A.

INFORMED CONSENT

PATIENT NAME:____DATE:_________________

I consent to having the following Endoscopic Examination/Procedure(s):

☐ **COLONOSCOPY**
With Possible Biopsy and/or Polypectomy

☐ **FLEXIBLE SIGMOIDOSCOPY**
With Possible Biopsy and/ or Polypectomy

☐ **HET BIPOLAR TREATMENT**

☐ **SMALL BOWEL ENTEROSCOPY**
With Possible Biopsy and/or Polypectomy

☐ **GASTROSCOPY(ESOPHAGO-GASTRO-DUODENOSCOPY)**
With Possible Biopsy and/or Polypectomy

I have been advised of the potential risks and benefits of the procedure(s) set forth above, as well as alternatives if any and the consequences of foregoing the procedure(s). I further understand that there may be serious complications such as loss of blood, infection, organ perforation or other calamitous occurrence, including death. I fully agree to accept all attendant discomforts and risks involved in my treatment and agree to cooperate with all physician instructions associated with my treatment.

It has been explained to me that during the course of the procedure(s), unforeseen conditions may be revealed that necessitate additional or different procedure(s) than those set forth above. I, therefore, authorize and request that Gastroenterology Diagnostics of Northern New Jersey, P.A. and their assistants and/or designees perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted shall extend to treating all conditions that are not known at the time the procedure is undertaken. I am aware that there may be a polyp or lesion that may be missed. I understand and acknowledge that no specific results, guarantees or assurances have been made to me as to the result that may be obtained from my treatment. The recommendation by my physician for treatment is based on available medical evidence and reasoned clinical judgment. I understand and acknowledge that there is no guarantee that the prescribed treatment will render a successful outcome.

I consent to the drawing of blood and testing for exposure to but not limited to syphilis, hepatitis and human deficiency virus in the event that any individual at Gastroenterology Diagnostics of Northern New Jersey, P.A. is accidentally exposed to my body fluids. The results of these tests will remain confidential, except as specified by law.

I understand that during the course of the procedure, photographs and/or other visual recording may be taken of the procedure and/or specimen and maintained as part of the Gastroenterology Diagnostics of Northern New Jersey, P.A. medical record. All such photographs and visual recordings will remain confidential to the extent required by applicable laws.

I also understand that my condition may require emergency transfer to an acute care facility and consent to such a transfer.

I acknowledge that I have had full opportunity to ask questions and have received all additional information and had all questions answered fully and to my satisfaction.

I certify that I have read this form and fully understand it contents.

THIS PATIENT CONSENT TO MEDICAL TREATMENT IS AND SHALL REMAIN VALID UNTIL REVOKED.

**You will receive this form at our facility