FALLSGROVE
ENDOSCOPY CENTER

Montgomery Anesthesia Care, LLC
Anesthesia Service

CONSENT FOR ANESTHESIA SERVICES

Patient Label:

1. I hereby authorize Montgomery Anesthesia Care, LLC anesthesia provider(s) to administer intra venous **sedation** for my procedure. This is accomplished by the injection through my intra venous catheter drugs that calm my anxiety and produce a semi-conscious state. My level of sedation might vary from light to deep, depending on my response to the medications and my medical needs. The intended plan for anesthesia is Deep sedation. Deep sedation is a drug induced depression of consciousness during which I cannot be easily aroused. While receiving anesthesia with or without sedation, I may be aware of my surroundings, may be able to hear and respond to my medical providers and/ or may remember some or all of the procedure. Although rare, my level of sedation may unintentionally progress to general anesthesia depending on my response to the medication given. Rarely, monitored anesthesia care cannot provide adequate relief or the medications used to sedate me may severely depress (lower) my breathing or slow my heart rate, requiring use of general anesthesia. I have been advised of the nature and purpose of the proposed anesthesia techniques.

2. I am aware that the practice of medicine and anesthesia is not an exact science and that there are risks and complications associated with the anesthesia and anesthesia techniques. I have been informed that aspirations of stomach contents in the lungs which may cause infection, drug reaction, airway trauma including but not limited to bruised lip or broken teeth, and rarely death and permanent brain damage are possible. I am comfortable with the explanation of potential benefits and risks involved with the anesthetic.

3. All of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed administration of anesthetic(s) and anesthetic techniques.

4. I authorize Montgomery Anesthesia Care, LLC, billing consultants to apply for benefits on my behalf and authorize all payments from my designated health care insurance to be made directly to Montgomery Anesthesia Care, LLC.

5. I authorize Montgomery Anesthesia Care, LLC to release any necessary information to my designated insurance carriers and all third party payers for the purposes of processing claims related to anesthesia services rendered.

6. I have been advised that one or more of the physicians in this practice have an ownership interest in **Montgomery Anesthesia Care, LLC**, the company that furnishes anesthesia services at **Fallsgrove Endoscopy Center, LLC.**

I certify that I have read or have been read the contents of this form, and that all questions have been answered to my satisfaction.

Patient/Authorized Designate Signature	**Date and Time**
Witness	**Physician/CRNA Obtaining Consent**