The following underlined physicians have an ownership interest in Sierra Endoscopy Center:

I HEREBY AUTHORIZE Andrew C. Chang, M.D., Aslam Godil, M.D., Roy L. Foliente, M.D., or Kevin Hill, D.O. and such associates as may be supplied by the Sierra Endoscopy Center, Inc., to perform a Colonoscopy and/or Esophagogastroduodenoscopy, which may include biopsy, polypectomy, cautery, dilation and/or injection therapy. I Further AUTHORIZE photographic evidence of the treatment or procedure for diagnostic use.
Dr. Chang, Dr. Godil, Dr. Foliente, or Dr. Hill has discussed with me the items that are summarized below:

I understand that these procedures have a small percentage of serious risks. The risks include, but are not limited to:
1) Perforation of the colon, esophagus, stomach, or small intestine, requiring surgery.
2) Bleeding, scarring and/or infection, from polypectomy or biopsy.
3) Possible infection of diseased or prosthetic heart valves.
4) Possible adverse reaction to intravenous anesthesia.

I AUTHORIZE my doctor to transfer me to Sierra Nevada Memorial Hospital, if any of the above risks are realized, and acknowledge that if such a transfer takes place, I will be responsible for the hospital bill.
The benefits of these procedures are:
1) The diagnosis or cause of bleeding, pain, difficulty swallowing, heartburn, or change in bowel habits.
2) The removal of pre-malignant or malignant polyps.
3) The diagnosis of cancer of the colon, esophagus, stomach or small intestine.
If this examination is refused, the possible consequences are:
1) continued bleeding (or pain) from sources in the colon, small intestine, esophagus or stomach.
2) Non-diagnosis of possible cancer in the G.I. tract, or inflammatory bowel disease.
3) The risk of polyps or other pre-malignant conditions becoming malignant resulting in bleeding, obstruction, or death.

Should a health care worker involved in my care and treatment become exposed to certain bodily fluids, resulting in the possibility of transmission of a blood-borne disease, my blood may be drawn and sent to a laboratory to be tested to detect whether or not I have antibodies to the Human Immunodeficiency Virus (HIV) or Hepatitis. By signature, I acknowledge that I have given consent for the performance of these test without a doctor's order. and give consent for the release of the results of the HIV and Hepatitis test to Sierra Endoscopy Center Registered Nursing Staff, only.

I am aware that the practice of medicine and surgery is not an exact science and that performance of procedures does not always guarantee a perfectly successful outcome. Sometimes lesions do not respond to therapy or are even missed. I have had sufficient opportunity to discuss my condition and treatment with Dr. Chang, Dr. Godil, Dr.Foliente, or Dr. Hill and his associates, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base the informed consent to the proposed procedure(s) and the administration of anesthesia. I also acknowledge that I have been given adequate time to make my decision and I understand that I can withdraw my consent at any time up to the time the procedure is started.

I consent to Colonoscopy and/or Esophagastroduodenoscopy – with possible: biopsy, polypectomy, dilation, cautery and or injection therapy with intravenous conscious sedation.

Patient Name _________________________ Patient Signature _____________________________________

Witness Name ________________________ Witness Signature ____________________________________
Witness to Signature Only

Date: ________________________ Time: ________________________

ENDOSCOPY AUTHORIZATION FOR AND
CONSENT TO SPECIAL DIAGNOSTIC OR
THERAPEUTIC PROCEDURES
SIERRA ENDOSCOPY CENTER, INC.