ROCHESTER GASTROENTEROLOGY ASSOCIATES, LLC
20 HAGEN DRIVE, SUITE 330 ROCHESTER, NY 14625
PHONE (585) 267-4040 FAX (585) 267-4044

AUTHORIZATION/CONSENT FOR PROCEDURE

I hereby authorize: ☐ Prasad Penmetsa, M.D., ☐ Surinder Devgun, M.D., ☐ Ari Chodos, M.D., ☐ Joseph Dytoc M.D., and whomever he/she may designate as their assistant, who is referred to as "the doctor" in the rest of this consent form, to perform the following procedures:

Colonoscopy (Lower GI Endoscopy) **Gastroscopy (Upper GI Endoscopy)** **Flexible Sigmoidoscopy**

Timeout Completed:_____
Signature Date

For the following conditions: _____

1. The Doctor has explained the condition and procedure to me. He/she has explained the purpose of the procedure and alternate way of treating the condition.
2. In addition to the usual risk of these procedures, I have been made aware of certain risks and consequences that are associated with the procedure(s). These include but are not limited to: bleeding, infection, perforation, etc.
3. I understand that during the procedure, the Doctor may discover a condition that he/she did not know or was not recognized before the procedure started. Therefore, I authorize the Doctor or his/her assistant to perform any additional or difficult procedures in accordance with the Doctor's judgment that are necessary or advisable while this procedure is being performed.
4. At the discretion of the Doctor, I consent to the presence of manufacturer's representatives to aid in the service and correct calibration of the instrumentation. I understand that at no time will these representatives actively participate in my procedure.
5. I consent to the administration of moderate (conscious) sedation by a Physician or Registered Nurse as the most appropriate for the procedure performed. The physician will discuss details regarding risks and alternatives appropriate for the procedure(s).
6. I consent to the administration of medications that may be necessary before, during or after the procedure(s).
7. I understand the Doctor may have assistants participate with him/her under his/her supervision in this procedure or related care.
8. I understand that a photo(s) may be made of the procedure and consent to this providing my right to privacy is protected.
9. I understand that no guarantees are made to me about the results of this procedure.

I have read this form. I understand what it means.

_____ _____ _____ _____
Patient Signature Date Parent/Legal Guardian Signature Date

_____ _____ _____ _____
Witness Date Doctor's Signature Date