CAPITAL ANESTHESIA
PARTNERS

CONSENT FOR ANESTHESIA SERVICES

Bethesda Chevy Chase DC Rockville Silver Spring

1. I hereby authorize Capital Anesthesia Partners, LLC to administer ***sedation*** by administering intravenous (injected through a catheter into your bloodstream) drugs to calm your anxiety and produce a semi-conscious state. Your level of sedation may vary from light to deep, depending on your response to the medications and your clinical needs. The intended plan for anesthesia is Deep Sedation. Deep Sedation is a drug-induced depression of consciousness during which you cannot be easily aroused. While receiving anesthesia with or without sedation, you may be aware of your surroundings, may be able to hear and respond to your medical providers and/or may remember some or all of the procedure. Although rare, your level of sedation may unintentionally progress to general anesthesia, depending on your response to the medications given. Rarely, MAC cannot provide adequate relief or the medications used to sedate you may severely depress (lower) your breathing or slow your heart rate, requiring use of general anesthesia.

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 aspiration (a condition where stomach contents enter the lungs and can cause an 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 Capital Anesthesia Partners, LLC's billing services/management company to apply for benefits on my behalf and authorize all payments from my designated health care insurance to be made directly to Capital Anesthesia Partners, LLC. I understand that I am responsible to Capital Anesthesia Partners, LLC for all charges, including those not covered by my insurance carrier. Returned checks for insufficient funds or closed accounts will be subject to a recovery fee not to exceed the State of Maryland's limit set by statute.

5. I authorize Capital Anesthesia Partners, LLC to release any necessary information to my designated insurance carrier(s) 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 has an ownership interest in Capital Anesthesia Partners, LLC – the company that furnishes anesthesia services at The Bethesda Endoscopy Center, LLC, Chevy Chase Endoscopy Center, LLC, The Endoscopy Center of Washington, DC, LLC, Endoscopic Surgical Centre of Maryland, LLC and Endoscopic Surgical Centre of Maryland-North, 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 Designated Signature _____ Date & Time _____

Witness _____ Physician/CRNA Obtaining Consent _____