Informed Consent and Release of Claims for

Administration of Anesthesia

Please read each item and initial only applicable sections then sign at bottom of the page

________ I understand and accept that there is risk associated any time anesthesia is administered, and though rare, complications may occur and have been discussed with me that include but are not limited to:

Allergic reaction	**Aspiration**	**Hoarseness**	**Sore Throat**
Brain Damage	**Coma**	**Blood Clot(DVT/STROKE/MI/PE)**	**Death**
Headache	**Infection**	**Muscle Ache**	**Phlebitis**
Nausea/Vomiting	**Eye Injury**	**Paralysis**	**Vocal Cord Damage**
Pneumonia	**Positional Nerve Injury**	**Awareness During Anesthesia**	**Heart Attack**

________ I understand that accidental dental injury is also a risk of anesthesia. The anesthesia provider cannot be held responsible for injuring teeth, partials, or dentures that are already damaged or in poor condition.

________ I certify that I have read, understand, and have fully complied with the pre-anesthesia instructions and intend to fully follow the post-anesthesia instructions.

________ I have informed the anesthesia provider and/or doctor of all my known allergies.

________ I have informed the anesthesia provider and/or doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use. I have further been advised which of these medications, if any, I should avoid taking surrounding the procedure date.

________ The anesthesia provider and doctor have answered all of my questions regarding the anesthesia and procedure.

________ **I ACKNOWLEDGE AND AGREE THAT ELITE ANESTHESIA ASSOCIATES, PLLC'S ("ELITE") ROLE IN MY CARE IS LIMITED TO ARRANGING FOR AN ANESTHESIA PROVIDER TO PROVIDE ANESTHESIA CARE AND RELATED SERVICES AND THAT SUCH ANESTHESIA PROVIDER IS DOING SO AS AN INDEPENDENT CONTRACTOR. THE ANESTHESIA PROVIDER IS SOLELY RESPONSIBLE FOR MY ANESTHESIA CARE AND ALL RELATED SERVICES. I HEREBY WAIVE AND RELEASE ELITE, ITS EMPLOYEES, MEMBERS, OFFICERS AND AFFILIATES FROM ANY AND ALL CLAIMS RELATED TO THE PERFORMANCE OF ANESTHESIA CARE AND ALL RELATED SERVICES BY THE ANESTHESIA PROVIDER**.

WOMEN AND TEENS OF CHILDBEARING AGE:

________ By initialing, I attest, to the best of my knowledge, that I am not currently pregnant. If there is any possibility that I may be pregnant, I am advised to have a pregnancy test performed before I undergo anesthesia. I may also choose not to be tested and accept full responsibility for the consequences of my decision. One or more of the anesthesia drugs are known teratogens. Human studies suggest that there is/are specific benzodiazepine-associated teratogenicity and congenital malformations could occur when it is administered at any time during pregnancy. Anesthesia drugs are recommended for use during pregnancy only when there are no alternatives and the benefit outweighs the risk. I understand my anesthetist is relying on my doctor for an opinion that the scheduled procedure today is prudent notwithstanding the risks. I choose to proceed with the procedure under anesthesia, understand and accept the risks, and acknowledge responsibility for the consequences of my decision-making regarding the procedure.

CHILDREN UNDER AGE 3

________ I understand that there is some scientific research supporting a conclusion that administering anesthesia to children under three years of age for more than three hours or on multiple occasions may negatively affect brain development or cause developmental delays. If requested, I may have the relevant FDA Communication provided to me. I understand my anesthetist is relying on my doctor for an opinion that the scheduled procedure today is medically necessary. I, too, agree that the procedure is medically necessary, understand and accept the risks, and acknowledge responsibility for the consequences of my decision-making regarding the procedure.

I have read and understand the risks associated with the administration of anesthesia and agree to proceed.

Sign____Relationship to patient ______________Date_____________________

PATIENT HEALTH HISTORY

Patient Name____Birthdate_______________Age________Gender_____

Weight ___________ lbs. Medications Taken Routinely____

ALLERGIES TO MEDICATIONS____

Proposed Procedure_____________________________________Doctor_______________________________________

Have you every had any complications with anesthesia? Y / N Is there a family History of Problems with anesthesia Y / N

Previous Anesthetics/surgeries____

Check any of the following WHICH APPLY to the patient

Pulmonary(Lungs)____None
__Asthma
__Reactive Airway
__Smoking/Vaping
__Bronchitis/Pneumonia(Last 6 weeks)
__COPD
__Emphysema
__Recent Strep throat infection
__Chronic Cough
__Other____________________

HEENT____None
__Sleep Apnea
__Snoring
__Enlarged Tonsils
__Difficulty Swallowing
__Glasses
__Hearing Aids
__Other_____________

Cardiac____None
__High Blood Pressure
__Heart Murmur
__Abnormal Heart Tests
__Congenital Heart Disease
__Irregular Heart Beat
__High Cholesterol
__Chest Pain
__Previous Heart Attack ________Date
__Pacemaker
__Coronary Artery Disease
__Other:________________

Neurological___None
__Seizures: Date of Last Siezure__________
__Paralysis/weakness
__CVA/Stroke/TIA: Date_______
__Chronic Headache/Migraine
__Other_________________

Musculoskeletal__None
__Cerebral Palsy
__Scoliosis
__Arthritis
__Muscular Dystrophy
__Other____________

Stomach Liver Kidney___None
__Acid Reflux/GERD
__Chronic Nausea/Vomiting
__Hiatal Hernia
__Feeding tube
__Hepatitis A,B,or C
__Liver disease(Cirrhosis)
__Kidney Disease
__Kidney Stones
__Peptic Ulcer Disease __Other____________

Endocrine__None
__Diabetes:Date of Last A1C_______________
__Thyroid disorder
__Adrenal Disorder
__Metabolic Disorder
__Other:______________

Blood Disorder__None
__Anemia
__Bleeding/Clotting Problems
__Easy Bruising
__Sickle Cell
__HIV/AIDS
__Other:____________

Other___None
__Autism
__Downs Syndrome
__ADD/ADHD
__Depression/Anxiety
__Developmental Delay
__Cancer:Type_____________

PATIENT OR GAURDIAN SIGNATURE____

PRE-OP Evaluation completed by CRNA NPO__________BP___/____Sp02_______ RR_____ HR_____Temp_____

Pulmonary_________________________________WNL
HEENT____________________________________WNL
Cardiac___________________________________WNL
Neurological_______________________________WNL
Musculoskeletal____________________________WNL
ASA Status I II III IV E

SLK____________________________________WNL
Endocrine_______________________________WNL
Blood Disorder___________________________WNL
Other__________________________________WNL
Anesthetic Plan: IV/IM GA/Intubation
Airway Exam: Malampati I II III IV

Anesthetic plan, alternatives, risks discussed with parent or legal guardian prior to the start of procedure_____

CRNA SIGNATURE____CRNA Date__________ Time________

Patient Financial Agreement

Patient Name_______________________________________Birthdate_______________________Age_____ Gender___________

Address____Apt#________ City____________________State___________

Parent or Gaurdian__________________________________Birthdate____________Age________Phone #____________________

Relationship to Patient_________________________________Email address____

Dental Insurance Co.___________________________________ID#________________________Group#_____________________

Medical Insurance Co.__________________________________ID#________________________Group#_____________________

Policy Holders Name_______________________________________Birthdate_________________Phone#____________________

Address____Apt#________City___________________________State_________

Relationship to Patient____________________________________Employer____________________________________

PAYER AGREEMENT:

- **We accept cash, check, money order, any credit card, and any debit card. We do not accept CareCredit.**
- ***Charges for anesthesia are as follows: $__________/hour for all anesthesia services. Prices are pro-rated to the minute after the first hour.***
- ***There is a one hour minimum charge***
- ***PAYMENT FOR ANESTHESIA IS DUE ON THE DAY OF SERVICE***
- **Please have a responsible adult with you, who knows your preferred payment method.**
- **Elite Anesthesia Associates will not bill insurance. However, we will provide you with proper documentation and proper ICD diagnosis codes for you to submit to your insurance if it is a covered benefit.**
- **Any delinquent or accrued charges may be sent to collections at a 33.37% interest rate.**

I have read, understand and agree to the payer agreement. I also understand that payment is due in full on the day of service.

Signed____ Date_________________ Time____________________