Grand Canyon Anesthesia/Scottsdale Anesthesia Associates, PLC
Consent for Anesthesia Services

I authorize the Anesthesiologist and or Certified Registered Nurse Anesthetist to provide anesthesia services as part of my upcoming surgery or procedure.

I understand and agree that the primary method of anesthesia administration will be deep sedation. This method has been discussed with me in terms that I can understand. If, in the course of treatment, conditions dictate a change in method, I understand and agree that this will be done at the discretion of the Anesthesia Provider in attendance.

Additionally, I authorize the performance of any other procedures that in the judgment of the Anesthesia Provider may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

I am satisfied with my understanding of the nature of the anesthesia plan of care and the more common drawbacks and complications associated with it. These may include, but are not limited to: swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to blood vessels; nerve damage; allergic reactions to the anesthetic agents; memory dysfunction/memory loss; nausea and vomiting; dental trauma, including fracture or loss of teeth, bridgework, dentures, dental implants, crowns and fillings, and laceration of the gums or lips; and prolonged recovery from anesthesia. There is also a rare potential for serious harm, including difficulties breathing, permanent organ damage, cardiac arrest, and death.

No warranty or guarantee has been made as to the outcome of the anesthesia plan of care.

I have been given the opportunity to ask questions about the anesthesia. I have been given explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives. I have received information regarding the drugs that may be used for my comfort and sedation (Propofol, Fentanyl, Versed, Demerol, and Lidocaine) including the anticipated results, potential adverse reactions/side effects, and the adverse reactions that could result from not taking the medications. I believe that I have sufficient information to give this informed consent.

I hereby authorize the billing agent for anesthesia services to appeal payment to my insurance company for anesthesia services concerning my procedure(s) performed on this date of service.

On my behalf, and as part of the appeal, I hereby authorize my insurance company in its decision letter and in connection with the processing of my appeal, to communicate with the billing agent in all aspects of the appeal.

I understand the information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of one year from the date signed.

The undersigned certifies that he/she has read the foregoing, had the opportunity to ask questions, and the patient, the patient's legal guardian, or the patient's representative accepts its terms.

_____ _____

Patient Signature Date/Time

Physician Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the anesthesia; the anticipated results, potential adverse reactions/side effects of the anesthesia medications; and have allowed the patient/responsible adult to ask questions.

_____ _____

Anesthesiologist Signature or CRNA Signature Date/Time