In order to continue delivering the same high-level standard of care to our patients as we did prior to the COVID-19 pandemic. We have adjusted our operating procedures to ensure the health and safety of our patients, our staff and our families.

Social distancing will be observed within our facility. We will be utilizing curbside check-in, consisting of patient's **texting or calling our office at: 803-719-5242**, upon your arrival. A staff member will then approach your vehicle to check your temperature with an infrared no-touch thermometer, gather some additional health information, provide hand sanitizer, and alert you when we are ready for your Pre-Op to begin. While curbside check-in minimizes patient exposure to other patients prior to being called back for their procedure, we do ask that your adult driver wait in the car during the procedure visit and that you will wear a mask at all times during your visit with us. Rest assured, our staff will inform your driver know when the procedure is done, provide preliminary finding and when you're ready for discharge.

With the implementation of additional safety measures, we have adjusted our scheduling for procedures as well. Unfortunately, we are unable to treat as many patients in a single day as we have in the past and we do run into delay, please come prepared with a time-frame of 3-4hours. We will contact you to adjust your scheduled procedure time in compliance with social-distancing guidelines on a case by case basis. In the event that you would like to reschedule your procedure for a later date, you may contact the office side at 803-788-1100 option 6.

We have provided you with a Berkeley Procedure Packet. Please review, sign and bring with on the day of the procedure. You may receive a call from our billing staff a couple days prior to the procedure date to collect any co-pays that may be applicable to your insurance benefits coverage.

We will try to keep you informed in these times of uncertainty and change.

Thank you, stay safe and healthy.

Siva K. Chockalingam, M.D.

ESCORT POLICY

Please note that your procedure cannot be performed unless your escort home is verified.

As a matter of patient safety, the Berkeley Endoscopy enforces the South State Ambulatory Surgical Center requirement that all patients having a procedure in our center have an escort; that is companion, family member or friend to accompany you home following your procedure.

PROCEDURE INFORMATION SHEET

An upper endoscopy or **EGD (EsophagoGastroDuodenoscopy)** involves the insertion of a lighted flexible tube, called an upper endoscope, into the mouth. The tube is guided by direct vision into the esophagus, stomach, and duodenum so that the lining of the upper gastrointestinal tract is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. Areas that are bleeding may be cauterized to stop active bleeding or to prevent future bleeding. An EGD is a generally safe procedure but carries several risks that include, but are not limited to, perforation and bleeding. Serious complications of EGD, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

A **colonoscopy** involves the insertion of a lighted flexible tube, called a colonoscope, into the rectum. The tube is inserted so that the lining of the entire colon is visualized. Any area of the lining that appears abnormal may be biopsied; that is, a piece of tissue may be removed for analysis. In addition, growths of the colon, called polyps, may be removed (polypectomy) by the use of an electrified wire, called a snare. A colonoscopy is generally a safe procedure but carries several risks that include, but are not limited to, the following: bleeding from biopsy or polypectomy; perforation or puncture of the colon which would likely require a surgical operation to repair; and, contact colitis; that is, irritation of the lining of the colon from contact with the colonoscope. Serious complications of colonoscopy, such as perforation or bleeding, are rare, but may require hospitalization, blood transfusions, or surgery.

Risks of the sedative medications include, but are not limited to, allergic reactions and respiratory depression. In addition to the risks described above about this procedure there are risks that may occur with any surgical or medical procedure. There can be no guarantees regarding the results of this procedure. Although endoscopic procedures are sensitive for the presence of gastrointestinal abnormalities, there is a risk that significant abnormalities of the gastrointestinal tract may not be detected by this procedure; this is especially true if the preparation of the gastrointestinal tract is not ideal.

Further information about these procedures can be obtained at the following organization websites:

The American College of Gastroenterology:
www.acg.gi.org/patients/
The American Society for Gastrointestinal Endoscopy:
www.askasge.org/

OWNERSHIP DISCLOSURE

Due to concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest,

This disclosure is intended to help you make a fully informed decision about your health care.

The Following Physicians Are the Owners of this Endoscopy Center:

Siva K. Chockalingam, M.D.

I, confirm that I have read and fully understand the above statements that have been presented/told to me in this document.

_____

Signature and Date

FINANCIAL POLICY

Your physician has chosen to perform your endoscopic procedure(s) at the Berkeley Endoscopy. Berkeley Endoscopy Center is a freestanding ambulatory surgical center [ASC] subject to South Carolina State and Federal regulations. It is not associated with your doctor's office and has separate financial and billing policies and procedures. We are committed to providing you with the best possible medical care at the lowest possible cost.

Berkeley Endoscopy Center will charge you for its facility services

The following is a statement of our Financial Policy that we require you read and sign prior to your treatment at Berkeley Endoscopy Center.

While your physician may participate in your insurance plan, Berkeley Endoscopy Center may or may not participate with your insurance plan. Prior to the date of your procedure, please verify the details of your insurance coverage with your insurance carrier. To further understand Berkeley Endoscopy Center's policy, please review the following:

If Berkeley Endoscopy participates with your insurance plan, the fees for your services will be billed to your insurance plan. However, you are responsible for the payment of your in-network deductible, copayments and/or co-insurance at the time of your procedure. These fees are mandated by your insurance carrier and cannot be waived. Please be prepared to pay these fees at the time of your procedure. We accept cash, checks, Visa, MasterCard, Discover, AMEX, or DEBIT cards with a Visa or MasterCard logo.

If Berkeley Endoscopy participates with the Medicare program, if you have Medicare coverage, you will be responsible for payment of the unmet deductible and the remaining 20 percent of the approved charge. Please be prepared to pay these fees at the time of your procedure. We accept cash, checks, Visa, MasterCard, Discover, AMEX, or DEBIT cards with a Visa or MasterCard logo.

If Berkeley Endoscopy does not participate with your insurance plan, Berkeley Endoscopy will bill your insurance plan. If you have "out-of-network" coverage, your insurance plan may cover a part of this charge. You are responsible for the payment of your deductible as well as any unpaid balance and **Berkeley Endoscopy** will bill you accordingly. If you have no "out-of-network" coverage, you will receive a bill from **Berkeley Endoscopy** for the facility fee. Some insurance plans will send Berkeley Endoscopy Center's facility fee payments directly to you. If you receive the payment for the services you received at Berkeley Endoscopy, you are responsible for forwarding the check directly to Berkeley Endoscopy. It is your responsibility to ensure the Center is paid the amount that has been sent to you. Be advised that not remitting the payment to Berkeley Endoscopy constitutes a breach of contract and Berkeley Endoscopy will pursue all legal remedies available to it to obtain such payment.

You are required to make payment arrangements prior to your procedure with the Financial Coordinator. If a payment arrangement is approved the following terms will apply. **THE EXTENDED PAYMENT PLAN IS SUBJECT TO THE FOLLOWING TERMS: A MINIMUM BALANCE SHOULD NOT EXCEED MORE THAN 6 MONTHS.**

All accounts with Financial Agreements that become delinquent 30 days from the last payment made (we do allow a grace period of ten days) will be placed in the collection's department for the appropriate action to be taken. As a courtesy, a billing statement and an Executed Financial Agreement will be sent to the Guarantor's address on file for your records.

All patient accounts with pending insurance or financial agreement and/or arrangement will have future credit limited until the previous balance is paid in full or a new written financial arrangement is made. The Business Manager and/or Financial Coordinator will be available to assist you in this matter.

In order to keep our fees to a minimum, we require that you pay at the time of service so that we do not have to send bills. All patients who have accounts with outstanding balances will have statements mailed on a monthly basis to their permanent address. You must remember that you are responsible for the bill unless you have made special arrangements approved in advance by the Business Manager and/or Financial Coordinator. A statement of your account will be provided containing information needed for tax or additional

insurance purposes at any time upon request.

If applicable, we may order complicated laboratory or specialized testing as a part of our comprehensive and follow-up evaluations. Payments for these tests are also due and payable at the time of service. Arrangements can be made in advance for payment of the cost of testing under our Extended Payment Plan.

As a result of the procedure, patients may have the following charges due to the nature of his or her procedure: a pathology fee (technical and professional component), a professional fee, and an anesthesia fee. Patients are expected to pay any fees pertaining to the procedure they are having.

Adult patients are responsible for full payment at their time of service.

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment in full at their time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard or payment by cash or check at time of service has been verified.

Patients may be required to establish a written financial arrangement for payment when services are rendered. If payment is made to our office, you will be notified when the insurance carrier remits payment. Our staff will apply this payment to your account and refund any credit balance within 30 days of receipt.

There is a $35.00 charge for returned checks. In some cases, returned checks may be referred to the District Attorney for collection.

_____

Signature of Patient or Responsible Party and Date

UNIFORM ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

I hereby authorize, assign and direct Berkeley Endoscopy Center, having treated me to release to governmental agencies, insurance carriers, or others who are financial liable for my medical care, all information needed to adjudicate claims and make payments for such Medicare care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I also authorize Berkeley Endoscopy Center, LLC to release medical information in the event to any emergency transfer to an Acute Care Facility. To include but not limited to Anesthesia Services and if any pathological services are rendered.

If I am transferred to or admitted to other institutions in relation to my procedure, I authorize the Berkeley Endoscopy Center, LLC to release all my medical records pertaining to that transfer or admission.

I hereby assign, authorize and transfer over to the Berkeley Endoscopy Center such monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financial liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent. I certify that the information given by me in applying for payment under Title XVIII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediates or carriers any information needed for this or a related Medicare claim. I authorize the physician or organization furnishing the services to me to submit a claim to Medicare or intermediaries for the services provided to me. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician services to the physician or organization furnishing the services to me.

FOR FINANCIAL AGREEMENT FOR PAYMENTS AND COLLECTIONS POLICY

All facility charges such as co-pay, co-insurance and deductible are due and owing on the day services are rendered In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payer. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at the maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payer as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

ACKNOWLEDGEMENT OF THE CONTENTS OF THIS FORM WILL OCCUR AT THE TIME OF THE APPOINTMENT. PLEASE FAMILIARIZE YOURSELF WITH THE CONTENTS OF THE BERKELEY ENDOSCOPY CENTER FINANCIAL AGREEMENT AND KEEP THIS COPY

_____

Patient Signature or Authorized Representative/ Date

Patient Acknowledgement

General Anesthesia Care

I understand and acknowledge that:

I will be receiving sedation for gastrointestinal endoscopy by board certified nurse anesthetist at Berkeley Endoscopy Center, LLC. Under Ether, L.L.C.

It is possible that General Sedation will not be covered under the terms of my insurance benefits plan.

If the service is not covered, I understand I may be responsible for a fee starting from $ 125.00 and no more than $250.00.

I understand I am responsible for paying any deductible or co-insurance as determined by my insurance company.

Signature and Date: _____

POLICY ON ADVANCE DIRECTIVES

Berkeley Endoscopy is an ambulatory surgical Center. Since the patient stay is expected to be brief (no overnight stay), **the Center does not accept "advance directives" such as "living will", "Health Care Power of Attorney" or "do not resuscitate (DNR)" orders**. If the patient chooses to maintain the "Advance Directive" status, the patient may seek treatment at facility such as a hospital that would accept the advance directives.

Living Will: A Living Will is a document that contains your health care wishes and is addressed to unnamed family, friends, hospitals and other health care facilities. You may use a Living Will to specify your wishes about life-prolonging procedures and other end-of-life care so that your specific instructions can be read by your caregivers when you are unable to communicate your wishes.

A Health Care Power of Attorney: is a person who is named by you to make health care decisions on your behalf if you are no longer able to do so. You may give this person (your agent) authority to make decisions for you in all medical situations. Thus, even in medical situations not anticipated by you, your agent can make decisions and ensure you are treated according to your wishes, values and beliefs. The South Carolina Law allows you to appoint someone you trust - for example, a family member or close friend - to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes.

Please contact for more information on the South Carolina Law in regards to "Advance Directives".

The Lieutenant Governor's Office on Aging
1-800-868-9095 or 803-734-9900
Or 1-888-5wishes (594-7437)

Do you have an advance directive on file with the State of South Carolina?

Please circle: Yes or No

PATIENT'S ACKNOWLEDGEMENT

I, acknowledge having been explained the policy on advance directives and agree to suspend these directives until I leave this facility. I have also been provided with a description of applicable state laws pertaining to Advance directives.

_____

(Patient, Representative, Relative) Signature and Date
[Circle Appropriate One]

BERKELEY ENDOSCOPY CENTER, L.L.C.

PATIENT RIGHTS

1. To become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. Patient may use appointed representative.
2. Exercise these rights without regard to race, sex, cultural, education or religious background or the source of payment for care.
3. To have considerate and respectful care, that protects their dignity and respects their physical, psychological, cultural, spiritual, and social health, provided in a safe environment. Respect for their property, Freedom from Mental and physical abuse and exploitation.
4. Remain free from seclusion or restraints of any form that are not medically necessary.
5. Coordinate his/her care with physicians and healthcare providers they will see.
6. Receive information from the physician about illness, course of treatment and the prospects for recovery in terms that he/she can understand.
7. Receive information about any proposed treatment or procedure as needed to give informed consent or to refuse treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment of non-treatment and the risks involved.
8. Have a family member or representative of his/her choice be involved in his care.
9. Full consideration of patient privacy concerning consultation, examination, treatment and surgery.
10. Confidential treatment of all communications and records pertaining to patient care. Written permission will be obtained before medical records can be released to anyone nor directly concerned with patient care.
11. Access information to his/her medical record within reasonable time frame (48 hours).
12. May leave the facility even against medical advice.
13. Have access to facility grievance process; to communicate any of his/her care problems. Grievances received can expect to have a response within 45 days.
14. Be informed by physician or designee to the continuing healthcare requirements after discharge.
15. Examine and receive an explanation of the bill regardless of source of payment.
16. Have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient. All facility personnel performing patient care shall observe these above rights.
17. Become informed the right to know, the physician financial interests or ownership in the Ambulatory Surgery Center. Disclosure of information will be in writing and furnished to the patient in advanced of the date of the procedure.
18. Provide the patient or, as appropriate, the patients representative in advance of the date of procedure with information concerning its policies on advance directives, including a description of applicable State health and safety law's and if requested, official State advance directive forms.
19. Become informed the right to refuse to participate in experimental research.
20. Become informed the right to change provider if other qualified providers are available.

PATIENT RESPONSIBILITIES

1. The patient has the responsibility to provide accurate and complete information to include medications taken i.e. OTC, dietary supplements, any allergies, sensitivities and any concerning present complaints, past illnesses, hospitalizations or any other health related issues.
2. The patient is responsible for making it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood.
3. The patient is responsible for following the treatment plan established by the physician, including instructions by nurses and other health care professionals, given by the physician.
4. The patient is responsible for keeping appointments or notifying the facility/physician in advance if unable to do so.
5. The patient accepts full responsibility for refusal of treatment and /or not following directions.
6. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
7. The patient is responsible for being respectful of the rights of others in the facility
8. The patient is responsible for the following facility policies and procedures.
9. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
10. Provide a responsible adult to transport him/her home from the facility.

Complaints Against The Surgery Center:

Bureau of Health Facilities Licensing
2600 Bull Street
Columbia, SC 29201-1708
(803) 545-4370

Complaints Against the Doctor:

Board of Medical Examiners
Synergy Business Park
Kingstree Building
110 Centerview Dr.
Suite 202
Columbia, SC 29210
(803) 896-4500

Complaints Against Nursing Staff:

Board of Nursing
Synergy Business Park
Kingstree Building
110 Centerview Dr.
Suite 202
Columbia, SC 29210
(803) 896-4550

For Medicare Inquiries:

The website for the office of Medicare Beneficiary Ombudsman is
www.medicare.gov/ombudsman/activities.asp

Signature and Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____

Patient Signature: / Personal Representative (as defined by HIPAA) Date

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____
  _____

PREGNANCY TEST POLICY
ONLY FOR WOMEN 50 YEARS AND BELOW

It is the policy of Berkeley Endoscopy Center that all the female patients who are in child bearing age and generally below fifty (50 years) will have a pregnancy screening urine test prior to the procedure. This testing is done to minimize the risk of potential adverse effects on a developing fetus.

You will not be required to have the pregnancy testing in the event you have had a procedure that prevents you from being pregnant such as sterilization procedure or hysterectomy etc. In that case please list the procedure you have had. Being on a birth control pill does not exclude you from having a pregnancy test done.

DECLINATION OF URINE PREGNANCY TEST

I am declining the Pre-procedure Urine pregnancy Test because I have had the following procedure:

1. Hysterectomy

Patient Signature _____ Date: _____

OR

I declare that I am not pregnant. I acknowledge that I understand the risks the fetus may be exposed to as a result of anesthesia if I were to be pregnant. With full knowledge of these risks, I am declining the urine pregnancy test offered to me by Berkeley Endoscopy Center. If I subsequently discover that I was pregnant and the baby suffered any anesthesia related complications, I hold Berkeley Endoscopy Center and all service providers at Berkeley Endoscopy Center harmless because I am declining the Urine Pregnancy Test.

Patient Signature_____ Date: _____

BERKELEY ENDOSCOPY CENTER, L.L.C.
Informed Consent for Endoscopic Procedure and Sedation / General Anesthesia

Explanation of Procedures

Gastrointestinal Endoscopy is a direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures. At the time of your examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may also be removed. To keep you comfortable during the procedure, medication, defined as General Anesthesia, will be administered by an anesthesia provider,(a CRNA). In the event an anesthesia provider is not utilized, your physician may administer medication defined as Conscious/Moderate Sedation.

Brief Description of Endoscopic Procedure

1. **EGD (Esophagogastroduodenoscopy):** Examination of the esophagus, stomach, and duodenum. Tissue samples (biopsies) may be removed if the physician deems necessary. If active bleeding is found, coagulation control by heat, medication, or mechanical clips may be performed.
2. **Esophageal Dilation:** Dilating tubes or balloons are used to stretch narrow areas of the esophagus.
3. **Colonoscopy:** Examination of all or a portion of the colon. Older patients and those with extensive diverticulosis are more prone to complications. Polypectomy (removal of small growths called polyps) is performed, if necessary, by the use of a wire loop and electric current. If active bleeding is found, coagulation control by heat, medication, or mechanical clips may be performed.

Principal Risks and Complications of Gastrointestinal Endoscopy

Gastrointestinal endoscopy is generally a low risk procedure. However, all of the following complications are possible. Your physician will discuss their frequency with you, if you desire, with particular reference to your own indications for gastrointestinal endoscopy. **YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR TEST.**

1. **Perforation:** Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required.
2. **Bleeding**: Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation, or may require transfusions, repeat endoscopy to stop the bleeding or possibly a surgical operation.
3**. Infection / Medication Phlebitis / Medication Reaction**: Infection or irritation resulting in inflammation (phlebitis) may occur at the Intravenous site and may require treatment. This can happen when the medications used for General Anesthesia and/or sedation may irritate the vein in which they are injected. This may cause a red, painful swelling of the vein and surrounding tissue and the area could become infected. Discomfort in the area may persist for several weeks to several months. Medication reaction such as drop in blood pressure, diminished breathing effort, irregular heart beat or allergic reaction.
4. **Other Risks include but are not limited to:** Post - Polypectomy Burn Syndrome, Drug reactions, and complications from other diseases or aggravation **of an existing medical condition** you may already have. Instrument failure and death are extremely rare but remain remote possibilities. Damage to teeth or dental work is not common, but may occur. This includes but is not limited to; cracking, chipping or complete loss of teeth as well as damage to prosthetics including bridges, implants, caps or crowns. Please inform your physician if you have any loose dental work, or easily removed bridges. **YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS**

Alternatives to Gastrointestinal Endoscopy: Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or misdiagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. I have the right to refuse the recommended procedure. Your physician will be happy to discuss these options with you.

I hereby authorize: X Dr. Siva K. Chockalingam

And whoever designated as his/her assistant (s)
To Perform:

_X__EGD _X___Colonoscopy ____ Flexible Sigmoidoscopy ____EGD/COLON

For the nature of my condition that my doctor discussed and explained to me.
I consent to the taking of any photographs during my procedure to assist in my care and for use in the advancement of medical education; for the presence of an observer during the procedure to provide assistance or consultation services to the physician.

I, certify and understand any tissue or specimen obtained may be sent to the laboratory/pathology for examination, disposal of, or be retained and preserved for research/educational purposes. I understand that saved tissue will not identify me in anyway.

I, certify that I understand the information regarding gastrointestinal endoscopy and moderate (conscious) sedation and/or General Anesthesia. I have been fully informed of the risks, benefits, alternatives and possible complications of my procedure with moderate (conscious) sedation and/or General Anesthesia.

I also understand that in the event of cardiac or respiratory arrest or other life threatening situation during my admission, the facility will perform the necessary life saving measures until transferred to a hospital should such methods become necessary and that my Advance Directives will not be honored at Berkeley Endoscopy Center, L.L.C. I give my consent for any medical treatment deemed necessary including transfer to a higher level of care.

I consent that it may be necessary to test the patients' blood while in the surgery center to protect against possible transmission of blood-Bourne diseases such as Hepatitis B or Acquired Deficiency Syndrome (AIDS). If for example, a Surgery Center Employee or physician is stuck by a needle, I understand and consent that the patients as well as the employee's or physician's blood will be tested (as appropriate) I further understand that the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with state and federal laws. I consent to having a peer physician review my medical record to obtain information about the delivery of medical care.

I, certify and understand that damage to teeth or dental work is not common, but may occur. This includes but is not limited to; cracking, chipping or complete loss of teeth as well as damage to prosthetics including bridges, implants, caps or crowns.

I know sedation and/or anesthesia (complete or partial loss of physical sensation) will be needed for the procedure. The risk for sedation includes but are not limited to an unconscious state, drop in blood pressure, depressed breathing and in rare cases can be fatal. I understand that I have been advised that I should not drive a vehicle, operate any heavy equipment and or sign any legal documents for twenty four (24) hours after sedation following my procedure.

If any unforeseen condition arises during the procedure calling for: in the physician's judgment, additional procedures, treatments, or operations, I authorize him/her to do whatever he/she deems advisable. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of this procedure. If there is any question that I might be pregnant, I will allow a urine pregnancy test to be performed prior to my procedure.

Patient /Legal Representative Signature: _____ Date: _____ Time: _____

Witness of Signature: _____Date:_____ Time: _____

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented to the procedure.

Physician Signature: _____ Date: _____ Time: _____

This patient is unable to confer consent related to: _____
Consent is therefore given by a.) Verbal b.) Phone or c.) Proxy

Signature of proxy: _____Relationship to Patient: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Berkeley Endoscopy Center, L.L.C.
Informed Consent
COVID-19 RISK

I understand that I am opting for an elective procedure that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Siva K. Chockalingam, M.D. and all the staff at Berkeley Endoscopy Center, L.L.C. are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective procedure, and I give my express permission for Siva K. Chockalingam, M.D. and all the staff at Berkeley Endoscopy Center, L.L.C. to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective procedure can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my procedure may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, and possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective procedure, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the procedure itself.

I have been given the option to defer my procedure to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired procedure.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.
Patient or Person Authorized to Sign for Patient: _____Date/Time_____
Witness: _____Date/Time_____
I have been offered a copy of this consent form (patient's initials) _____