

Gastroenterology Associates of Fairfield County PC  
d/b/a The Endoscopy Center of Fairfield  
Name:

DOB: SharedID:

**Notification to Patients**

Please read the following statements and place your initials after each statement.

**Patient Rights and Responsibilities**

- I have been informed of my patient rights and responsibilities \_\_\_\_\_

**Advance Directives**

- I have been informed of my rights to formulate an Advance Directive and understand that I am not required to have Advance Directive in order to receive medical treatment in this healthcare facility  
\_\_\_\_\_
- I understand that it is the policy of this surgery center to resuscitate all patients that require resuscitation in order to maintain their vital functions. \_\_\_\_\_
- I understand that in the case of a medical emergency that I may be transferred to the local hospital.  
\_\_\_\_\_
- Please check one of the following statements:  
\_\_\_\_\_ I have formulated an Advance Directive  
\_\_\_\_\_ I have not formulated an Advance Directive

**Disclosure of Ownership Information**

A corporation formed by the physicians owns this facility. These physicians have become owners as a result of their commitment to quality healthcare and to provide better services to their patients. Your physician may be an owner in or of this Facility. \_\_\_\_\_

- I consent to the care at the Endoscopy Center of Gastroenterology Associates of Fairfield County with the knowledge that this facility is owned exclusively by the physicians of Gastroenterology Associates of Fairfield County and that I have voluntarily chosen this facility over similar facilities in the area. \_\_\_\_\_

**Statement of Compliance**

If I am having any form of conscious sedation, spinal or general anesthesia, I certify that I have a responsible adult driver to take me home after my procedure. I understand that if I do not have a driver, my procedure can be cancelled. Please state the driver's name and telephone number.

\_\_\_\_\_  
Name of Driver

\_\_\_\_\_  
Driver's telephone #

I have been advised not to drive a car or operate any machinery until the following day unless otherwise indicated by the physician.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date