Informed Consent

Patient Name: _____

DOB: _____

Today's Date: _____

1. I understand that the following exam has been ordered by my health care provider,_____ and will be placed by a specially trained Registered Nurse employed by MNGI Digestive Health or other health care providers as deemed necessary. ***[Circle]***

Esophageal Manometry	pH Probe 24 Hour
Anorectal Manometry	Biofeedback

2. The risks and benefits of this procedure/treatment have been explained to me in terms I understand. I have been informed of the possibility of complications resulting from the procedure/treatment. I have had an opportunity to ask any questions I have concerning the procedure/treatment.

3. In the event the staff is exposed to my blood, body fluids or contaminated material, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory will

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perform all required tests at no cost to me. I understand I will be told if this occurs, and I will be given the results of my blood tests.

4. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s)/treatments(s).

5. I understand that any healthcare encounter, including this procedure, may present a risk of COVID-19 transmission.

Signature of Patient/Legal Guardian:

_____

Date/Time: _____

Witness Signature:

_____

Date/Time: _____

If patient is unable to sign permit, state reason:

_____