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ENDOSCOPIC OFFICE EXAM CONSENT

What is it?
Some parts of the ear, nose and throat area are difficult to accurately examine. I recommend endoscopy to provide the best possible view of your nose sinus, throat and/or voice box. In this procedure, I will pass a slender telescope through your nose toward your throat to check critical areas of the head and neck. Prior to passing the endoscope, I will spray your nose with anesthetic and possibly a decongestant.

What are the advantages?
Endoscopy is quick, has only mild discomfort, and is highly accurate. It is one of the most accurate ways of checking the nose and throat for abnormalities. Without endoscopy, such a detailed examination would require general anesthesia.

What are the disadvantages?
There are no major risks. There can be slight bleeding, but this is extremely rare. I have not seen any patients develop an infection from this procedure.

What about insurance?
This procedure is almost always covered by insurance. Some insurance companies will list this procedure on your statement (Explanation of Benefits) as “surgery” or as a “surgical procedure” instead of as a procedure (“surgeries”) like this. If you have any questions please speak with our billing department. Alternatives to this procedure include CT, MRI and PET scan as well as examination under anesthesia, all of which are more costly than endoscopy.

What if I decide NOT to do it?
I think that this procedure is important; otherwise I would not be recommending it. It is my opinion that NOT performing this examination could prevent me from adequately diagnosing an infection, serious condition, or in some cases even a cancer or other life-threatening process.

I have read the above information and AGREE to the endoscopic examination.

Patient Signature:_____ Date:_____

Print last name: _____ DOB: _____

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Sign below only If you DECLINE endoscopy:
I have read the above information, and at this time I do NOT want to proceed with the endoscopic exam. I understand that this may compromise my doctor’s ability to diagnoses and treat my problem, including inability to visualize a cancer or other life-threatening process.

Patient Signature:_____ Date: _____

Print last name: _____ DOB: _____