ADVANCED SURGICAL CENTER

ALL ACKNOWLEDGEMENT

I hereby acknowledge that I have received, read, and understand the Patient Rights and Responsibilities policy on Advance Directives, Physician Ownership Disclosure, and the Patient's Notice of Privacy Practices.

1. I HAVE RECEIVED THE PATIENT RIGHTS AND RESPONSIBILITIES INCLUDING INFORMATION ON WHOM I MAY VOICE COMPLAINTS/GRIEVANCES TO.

2. I HAVE RECEIVED THE FACILITY'S POLICY ON ADVACNED DIRECTIVES.

3. I AM AWARE OF THE PHYSICIAN OWNERSHIP/FINANCIAL INTEREST OF THE FACILITY.

4. I HAVE RECEIVED A COPY OF THE PATIENT'S NOTICE OF PRIVACY PRACTICES.

- I **HAVE NOT** PROVIDED AN ADVANCE DIRECTIVE FOR MY MEDICAL RECORD
- I **HAVE** AN ADVANCE DIRECTIVE IN EFFECT AND I HAVE PROVIDED THE CENTER WITH A COPY.

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Patient/Patient Représentative Signature Date