DISCLOSURE OF OWNERSHIP:

I understand that one or more of the physicians providing my treatment may have ownership interest in this facility. I understand that I may choose any facility for the purpose of having this outpatient procedure and I have chosen Coast Surgery Center, LP.

PATIENT SELF-DETERMINATION ACT

Coast Surgery Center Statement of Limitation Regarding Advance Healthcare Directive: Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care. It is the policy of Coast Surgery Center to not honor the Do Not Resuscitate (DNR) stipulations of an Advanced Directive/Living Will. If an adverse event occurs during your treatment, the medical team will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.

At the time of admission, does the patient have an **Advance Health Care Directive** (i.e. Durable Power of Attorney for Health Care, a Living Will, or a California Declaration)?

- □ Yes, patient has an Advance Directive □ Copy provided, in Chart □ No Copy provided
- □ No, patient does not have an Advance Directive
- □ Patient is a Minor / Child

PATIENT ACKNOWLEDGES:

I acknowledge I have either received from my physician's office, or reviewed on Coast Surgery Center's web-site, information regarding ***Patient Rights and Responsibilities,*** information on physician ***Ownership Interest,*** and the center's ***Advance Directive Policy.***

Upon request, Coast Surgery Center is happy to provide you with a copy of the State of California Advance Health Care Directive form.

☐ I have received additional information / ☐ I have declined additional information concerning an individual's rights under state law (statutory or recognized by the courts of the state) to make decisions concerning health care, including the right to accept or refuse health care and the right to formulate advance directives.

I acknowledge that I have received a copy of the Privacy Notice for Coast Surgery Center.

Privacy Notice Revised: April 21, 2013
Rights and Responsibilities Revised May 31, 2013

_____ _____
Patient or Legal Representative Signature Date

_____
Facility Representative

CENTER USE ONLY

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, *acknowledgement has not been obtained* because:

- □ Patient refused to sign the Privacy Notice Acknowledgement
- □ Patient was unable to sign because: _____
- □ Other reason (described here): _____

_____ _____
Employee Signature Date

COAST SURGERY CENTER	
Patient Acknowledgement	