ACKNOWLEDGEMENT OF RECEIPT OF FORMS

PATIENT: _____ DOB: _____

PHYSICIAN: _____ DATE OF SERVICE: _____

As part of Grant Surgicenter's ongoing commitment to provide patients with complete disclosure about its ambulatory surgery facility and standard of care policies, the following information has been provided to you at least one day prior to your scheduled procedure:

By signing below, I acknowledge that I have received verbal and written notification of Grant Surgicenter's:

____ Patient Bill of Rights and Responsibilities

____ Disclosure of Grant Surgicenter Ownership

____ Advance Directives

Additionally, if I have an Advanced Directive, I will provide a copy to Grant Surgicenter.

____ I understand that any Advance Directive I have will not be honored at the Grant Surgicenter as this is an outpatient surgery center and all measures necessary for resuscitation will be executed at this center.

_____ _____

Patient Signature Date

FINANCIAL OBLIGATION

By signing below, I acknowledge I have been given all necessary information regarding my procedure to include the facility fee if required by my insurance. This must be paid at the time of the procedure. If there is any change in my insurance between now and the time of the procedure, I will be responsible for contacting the office so they may contact my insurance company for any facility fee.

_____ _____

Patient Signature Date