



Patient:
 DOB: Age:
 Patient#: AC#:
 Physician:
 DOS: Sex:

Advance Notice Patient Attestation

PATIENT INFO.

Last Name	First Name	Middle Name	DOB
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Age	Gender	Performing	Anesthesiologist
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Procedure Description	Pre Op Diagnosis	Allergies	Patient Medication
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

In accordance with Medicare's Condition of Coverage for Ambulatory Surgical Centers, the following information has been provided to you, verbally and in writing, prior to procedure at the Surgery Center.

- 1. Statement of Financial Interest: I was advised that my doctor may maintain a financial interest in this Surgery Center. The doctors who have a financial interest are: Peter Andrews, William Benedict, Justin Kanoff, Joel Meyers, Micah Rothstein, Anjali Sheth and Elisha Tilton.
- 2. Statement of Patient's Rights: A copy of the Patient's Rights and Responsibilities and Grievance Procedure has been provided to me prior to the date of my initial procedure at this Center.
- 3. Advance Directive: Statement of Limitation:

This facility does not provide implementation of advanced directives; on the basis of conscience (the scheduled procedure is an elective procedure), regardless of the contents of any advance directive or instructions from a health care surrogate or attorney. If an adverse event occurs at this facility, we will initiate resuscitative or other stabilizing measures and transfer patient to an acute care hospital for further evaluation. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney.