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

# Advance Notice Patient Attestation

**PATIENT INFO.**

| Last Name | First Name | Middle Name | DOB |
|---|---|---|---|
| | | | |

| Age | Gender | Performing | Anesthesiologist |
|---|---|---|---|
| | | | |

| Procedure Description | Pre Op Diagnosis | Allergies | Patient Medication |
|---|---|---|---|
| | | | |

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.

☐ 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.