



ACKNOWLEDGEMENTS

Ownership Disclosure

I am aware that my physician may have ownership interest in Seven Hills Surgery Center. I understand that I may choose another facility for the purpose of having the procedure performed.

I have decided to have my procedure performed at Seven Hills Surgery Center.

I acknowledge I was notified in advance of the date of the procedure of this disclosure.

Patient (Patient's Representative) Signature

Date

Patient Rights & Responsibilities

I acknowledge that I have received a copy of Seven Hills Surgery Center's Patient Rights & Responsibilities in advance of the date of the procedure. I understand that I may address any questions I have regarding the form to the facility's representative.

Patient (Patient's Representative) Signature

Date

Advance Directives

I acknowledge that I have received a copy of Seven Hills Surgery Center's policy on Advance Directives in advance of the date of the procedure. I understand that I may address any questions I have regarding the form to the facility's representative.

Patient (Patient's Representative) Signature

Date

Notice of Privacy Practice

I acknowledge that I have received a copy of Seven Hills Surgery Center's Notice of Privacy Practice in advance of the date of the procedure. I understand that I may address any questions I have regarding the form to the facility's representative.

Patient (Patient's Representative) Signature

Date
