WESTCHASE SURGERY CENTER

Advance Directives. I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advanced directive or living will, the surgery center will not honor any requests not to resuscitate and will transfer me to a hospital which will make decisions about following any advance directives or living will. If I should be transferred to a hospital, I authorize to the hospital to release copies of my medical records to the surgery center to review the episode of care.

I have the following:	Copy given to Surgery Center
___ Living Will	___
___ Health care surrogate, proxy or durable POA	___
___ Power of Attorney	___
___ Evidence of Guardianship	___
___ None of the above	___

Legal Relationship between Surgery Center and Physicians. I understand that all physicians furnishing services to the patient, including my Treating Doctor, and any specialist such as an anesthesia provider, radiologist and pathologist are independent contractors with the patient and are not employees or agents of WESTCHASE SURGERY CENTER. I understand that I am under the care and supervision of my Treating Doctor and that the surgery center and its staff carry out instructions of my Treating Doctor.

Radiology and Lab Services. I understand that my Treating Doctor may have a professional radiology service review radiological images. My Treating Doctor may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physician and laboratories.

Equipment / supplies. I understand that my Treating Doctor may choose to prescribe additional supplies or equipment for my aftercare use and that these services are billed separately by the medical company.

Personal Effects. I release the Surgery Center from any responsibility for loss or damage to money, jewelry, or other personal effects that I bring into the Surgery Center.

I acknowledge that I have received and understand the following information prior to the procedure.

___ Patient Rights and Responsibilities
___ Advanced Directives
___ Physician Ownership Disclosure
___ Posted Grievence Procedures
___ Patient Privacy Notice

I CERTIFY that I have read and fully understand the above information that the procedure has been fully explained by my Treating Doctor, and I authorize and consent to the performance of the procedure.

___ **Permission** to-give protected health information **(PHI)** to a responsible adult companion **(RAC)**

Name of Responsible Adult Companion _____

Patient's signature **Date and Time**

If patient's personal representative, state relationship and authority:

Representative's Signature **Printed Name** **Relationship** **Date and Time**

Witness' Signature **Printed Name** **Date and Time**

ID / Visit: /
DOS:
Sex:
DOB:
Age:
Phys: