ACKNOWLEDGEMENT OF ADVANCE NOTIFICATION

PATIENT: ________________________________
DOB: ________________________________
AGE: ________________________________

SURGEON: ________________________________
TCSC MR#: ________________________________

PCP: ______________________________________
REFERRING PHYS.: __________________________

As part of Tri-County Surgery Center'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 Tri County Surgery Center's:

__ Patient Bill of Rights and Responsibilities

__ Disclosure of Tri-County Surgery Center Ownership

__ Grievance Policy

__ Advance Directive Policy

Additionally, if I have Advanced Directives, I will provide a copy to Tri-County Surgery Center.

__ Yes, I have Advanced Directives and will provide a copy

__ No, I do not have Advance Directives and have been provided information regarding such

______________________________ ______________
Patient Signature Date