RECEIPT OF PATIENT INFORMATION

Patient name: _____
Date of Surgery: _____

I acknowledge that prior to my procedure at the Surgery Center of Silverdale, LLC, I was provided with the following important information relating to my services:

Owner Information
Patient Rights
Patient Responsibilities
How to Report a Complaint
Advance Directives Policy
General Instructions / What to Expect
Financial & Billing Policy
Notice of Privacy Practices

I have an Advance Directive: ☐ Yes ☐ No

I would like more information regarding how to complete an Advance Directive: ☐ Yes ☐ No

By my signature below, I acknowledge that:

- I have read and understand this information and my questions have been answered satisfactorily by the Surgery Center staff.
- I agree to comply by the terms of the Financial and Billing Policy and if my account is sent to collections there will be a $25 fee.
- I will have a responsible adult escort me from the surgery center and stay with me for 24 hours following my procedure.

Signature: _____

Date: _____