STONECREEK
SURGERY CENTER

ACKNOWLEDGEMENTS

Ownership Disclosure

I am aware that my physician may have ownership interest in Stonecreek 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 Stonecreek Surgery Center. I acknowledge I was notified in advance of the date of the procedure of this disclosure.

Patient Rights and Responsibilities

_____ I acknowledge that I have received a copy of Stonecreek Surgery Center's Patient Right's & Responsibilities in advance of the date of the procedure. I understand that I may address any question I have regarding this form to the facility's representative.

Advance Directives

_____ I acknowledge that I have received a copy of Stonecreek 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.

Notice of Privacy Act

_____ I acknowledge that I have received a copy of Stonecreek 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 Representative) Signature Date

_____ _____

Witness Date