

Patient Notification and Acknowledgement

Notice of Rights

Sillect Surgery Group, LLC has established a Patient's Bill of Rights, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. Sillect Surgery Group, LLC expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the facility.

Financial Disclosure

Sillect Surgery Group, LLC is privately owned and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health related services.

Advance Directives

It is the policy of Sillect Surgery Group, LLC, regardless of any advance directives or instructions from a health care surrogate or power of attorney, that an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check the appropriate box. Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

- Yes**, I have an advance health care directive, living will and/or a power of attorney.
- I have provided my advance health care directive, living will and/or a power of attorney to SSI.
- No**, I do not have an advance health care directive, living will and/or a power of attorney.
- I would like additional information on advance health care directives
(PLEASE ASK RECEPTIONIST FOR PAMPHLET)

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on notice of patient rights, financial disclosure and advance directives. I agree to the policies of Sillect Surgery Group, LLC. If I have indicated I would like additional information, I acknowledge receipt of that information.

Patient Signature (If patient is unable to sign, please indicate relationship)

Date

Witness Signature

Date



Patient Sticker

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received Sillect Surgery Group, LLC's Privacy Notice.

**Patient or Personal Representative
Signature**

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

Witness Signature: