Patient Acknowledgment Form

I, _____ , acting as a (circle appropriate designation) patient, patient's representative, relative, do hereby acknowledge that I received, reviewed and had the opportunity to ask any questions about the following documents:

* Patient Rights and Responsibilities
* Information on Advance Directives
* Disclosure of Financial Interest in the facility
* Notice of Privacy Practices

Designation Statement

I, _____ , designate the following person to be able to speak to a physician or Surgery Center South staff, should it be necessary, on my behalf. I hereby give permission to Surgery Center South through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release Surgery Center South, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____

Relationship: _____ Phone Number: _____ (home /work)
Patient's Name: _____

Patient's Signature: _____

Date: _____ Witness: _____

☐ **I decline to designate another person to speak with my physician or surgery Center South staff.**

Ethnicity: _____ Race: _____

I further do here by acknowledge that the Patient Rights and Responsibilities and Surgery Center South's policies regarding advance directives were verbally explained to me by a representative of this facility to my satisfaction.

I further attest that I have informed Surgery Center South of the existence, if any, of instructions pertaining to advance directives, living wills, DNR order, health care proxies or other forms of expression of patient self-determination.

I have an advance directive: ☐ NO ☐ YES Type: _____

I ( ) have provided or ( ) will provide a copy of any duly executed instrument and acknowledge that said copy will become a part of my medical record.

I understand and acknowledge that it is the responsibility of the patient, or his/her representative, to inform Surgery Center South immediately of any change in the conditions of the above-mentioned expression of patient self-determination.

_____ _____
Print Patient's Name | Signature of Patient, Representative, Relative (Circle appropriate designation)

_____ _____
Date | Witness (Signature/Title)