

LAKE MARY SURGERY CENTER

Advance Directives. I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advanced directive or living will, the surgery center will not honor any requests not to resuscitate and will transfer me to a hospital which will make decisions about following any advance directives or living will. If I should be transferred to a hospital, I authorize to the hospital to release copies of my medical records to the surgery center to review the episode of care.

I have the following:	Copy given to Surgery Center
<input type="checkbox"/> Living Will	_____
<input type="checkbox"/> Health care surrogate, proxy or durable POA	_____
<input type="checkbox"/> Power of Attorney	_____
<input type="checkbox"/> Evidence of Guardianship	_____
<input type="checkbox"/> None of the above	_____

Legal Relationship between Surgery Center and Physicians. I understand that all physicians furnishing services to the patient, including my Treating Doctor, and any specialist such as an anesthesia provider, radiologist and pathologist are independent contractors with the patient and are not employees or agents of LAKE MARY SURGERY CENTER. I understand that I am under the care and supervision of my Treating Doctor and that the surgery center and its staff carry out instructions of my Treating Doctor.

Radiology and Lab Services. I understand that my Treating Doctor may have a professional radiology service review radiological images. My Treating Doctor may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physician and laboratories.

Equipment / supplies. I understand that my Treating Doctor may choose to prescribe additional supplies or equipment for my aftercare use and that these services are billed separately by the medical company.

Personal Effects. I release the Surgery Center from any responsibility for loss or damage to money, jewelry, or other personal effects that I bring into the Surgery Center.

I acknowledge that I have received and understand the following information prior to the procedure.

<input type="checkbox"/> Patient Rights and Responsibilities	<input type="checkbox"/> Posted Grievance Procedures
<input type="checkbox"/> Advanced Directives	<input type="checkbox"/> Patient Privacy Notice
<input type="checkbox"/> Physician Ownership Disclosure	

I CERTIFY that I have read and fully understand the above information that the procedure has been fully explained by my Treating Doctor, and I authorize and consent to the performance of the procedure.

Permission to-give protected health information (**PHI**) to a responsible adult companion (**RAC**)

Name of Responsible Adult Companion _____

Patient's signature	Date and Time
If patient's personal representative, state relationship and authority:	

Representative's Signature	Printed Name	Relationship	Date and Time
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Witness' Signature	Printed Name	Date and Time	
			ID / Visit: /
			DOS:
			Sex:
			Age:
			DOB:
			Phys: