OASIS SURGERY CENTER

ASC Conditions of Coverage Patient Attestation

Patient Name:____

Date of Procedure:_______________

Physician's Name: _________________________________

I certify that I have received written documentation of the following items, in advance of the date of my scheduled procedure:

1. Patient's Rights and Responsibilities
2. The Oasis Surgery Center policy concerning Advance Directives
3. Disclosure of Physician Ownership

Furthermore, I understand that this information is being provided for my benefit and that should I have any questions regarding its content, I should contact the Oasis Surgery Center for clarification.

____ ___________________
Patient Signature Date

<u>If patient is a minor or unable to sign complete the following:</u>

□ Patient is a minor □ Patient is unable to sign because______________________________

____ ___________________
Patient Signature Date

Relationship: _______________________________________