NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

This facility is owned by a corporation formed by physicians. These physicians have become owners as a result of the commitment to quality healthcare and service to their patients. Your physician may be an owner in or of this facility.

Please be advised of the following:

The facility may have a financial relationship with your physician as indicated above. A schedule of the typical fees for service provided by the facility is available at your request. You have the right to choose where to receive these services, including an entity in which your physician may have a financial relationship.

Two reasonable alternative sources of services available are:

1. Bay Medical Center
   615 N. Bonita Ave.
   Panama City, FL 32401 850-769-1511
2. Gulf Coast Medical Center
   449 West 23rd Street
   Panama City, FL 32405 850-769-8341

Patient Initials __________

Notice of Policy Regarding Advance Directives

This facility requires the following notice to be signed by each patient prior to scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) AND State Law regarding Advance Directives. Advance Directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual in unable to make those determinations and who is authorized to make those decisions. The Advance Directives are made and witnessed prior to serious illness or injury.
There are many types of Advance Directives, but the two most common forms are:
Living Wills: These generally state the type of medical care in individual wants or does not want if he/she becomes unable to make his/her own decisions.
Durable Power of Attorney for Health Care: This is a signed, dated and witnessed paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.
In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life threatening situation, the signed consent implies consent for resuscitations and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed advance directives for any patient. If you disagree, you must address this issue with your physician prior to signing this form.

By my signature below, I am acknowledging that I have read and fully understand my responsibilities, this Facility's policy regarding Advance Directives and my physician's possible financial interest in this facility, and that I received this information 24 hours in advance of my procedure.

I do _________ do not _______ have signed Advance Directive.

I do _________ do not _______ desire further information on Advance Directives.

Patient Initials __________

PATIENT RIGHTS AND RESPONSIBILITIES

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of the: LASER AND SURGERY CENTER

The patient has the right:

- To be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- To prompt and reasonable response to questions and requests.
- To know who is providing medical services and who is responsible for his or her care.
- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- To know what rules and regulations apply to his or her conduct.

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• To be given by the health care provider, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
• To refuse treatment, except as otherwise provided by law.
• To be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
• To know, upon request and in advance of treatment, whether the health care provider of health care facility accepts the Medicare assignment rate.
• To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
• To receive a copy of reasonably clear and understandable, itemized bill and upon request, have the charges explained.
• Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.
• To receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
• To know if medical treatment is for purposes of experimental/research and to give his or her consent or refusal to participate in such experimental research.
• To express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of this health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible
• For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
• For reporting unexpected changes in his or her condition to the health care provider.
• For following the treatment plan recommended by the health care provider.
• For keeping appointments and when he or she is nable to do so for any reason, for notifying the health care facility.
• For his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
• For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
• For following health care and facility rules and regulations as they affect patient care of conduct.

FILING COMPLAINTS

If you have a complaint against an ambulatory surgical center,
call the Consumer Assistance Unit at 888-419-3456 (press 1
or on the web at www.fdhc.state.fl.us
or write to:
Agency of Health Care Administration
Consumer Assistance Unit
2727 Mahan Drive, Bldg 1
Tallahassee, FL 32306

If you have a complaint against a health care professional and want to receive a complaint form,
call the Consumer Assistance Unit at 888-419-3456 (press 2)
or on the web at www.fdhc.state.fl.us
or write to:
Agency of Health Care Administration
Consumer Assistance Unit
P.O. Box 14000
Tallahassee, FL 32317-4000

By signing this form I acknowledge that I have read and understand the foregoing statements at least 24 hours prior to my surgery.

1) Notice of Disclosure of Ownership Interest
2) Policy on Advance Directives
3) Patient Rights
4) Patient Responsibilities

______________________________ ________________________

Patient Signature **Date**