GLENWOOD SURGERY CENTER

an affiliate of **SCA**

ASC Conditions of Coverage Patient Attestation

Patient Name:_____ **Date of Procedure:**_____

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. Glenwood Surgery Center's policy concerning Advance Directives (NA for minors)
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 Glenwood Surgery Center for clarification.

_____ _____

Patient Signature/ Parent of Minor Child Date