The Endoscopy Center of Fairfield –

Patient Notification of Advanced Directives and Ownership

Name: SharedID:

DOB:

Advance Directive

I have formulated Advance Directives Yes ☐ No ☐

In compliance with the Federal and State laws and rules regarding advance directives, our facility requires each patient to read and acknowledge the facility position on advance directives prior to your scheduled procedure.

Advance Directives are statements that indicate the type of medical treatment wanted or not wanted in the event of an emergency. It is our policy to resuscitate all patients that require resuscitation in order to maintain their vital signs. In the event of a medical emergency, resuscitation will be instituted in every instance and the patients will be transferred to the local hospital.

Advance Directives are not honored here. If for any reason you disagree with this policy, please discuss this with your physician before arriving for your procedure.

I have read and acknowledge that the Facility does not honor Advance Directives.

Patient's Signature:_____ Date:_____

Witness Signature: _____ Date:_____

Disclosure of Ownership Information

A corporation formed by physicians owns this facility. These physicians have become owners as a result of their 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 typical fees for services provided by the facility is available at your request.

You have the right to choose where to receive services, including an entity in which your physician may have financial relationship.

You have made the decision to come to this facility on your own free will.

I have received a patient's rights and responsibility form.

Patients' Signature:_____ Date:_____

Witness Signature: _____ Date: _____

Statement of Compliance

If I am having any form of conscious sedation, or anesthesia, I certify that I have a responsible adult driver to take me home after my procedure. I understand that if I do not have a driver, my procedure can be cancelled. Please state the driver's name and telephone number.

_____ _____

Name of Driver Driver's telephone #

I have been advised not to drive a car or operate any machinery until the following day unless otherwise indicated by the physician.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Patient scheduled for procedure. Date:_____

No office visit scheduled prior to procedure: Person Mailing Form:_____

Mailed/Faxed forms to patient along with prep. Fax or Address sent to:_____