American Surgical CENTERS

A DIVISION OF AMERICAN SURGICAL CORPORATION

RECEIPT OF INFORMATION FROM AMERICAN SURGICAL CENTERS

I acknowledge receipt of information prior to my date of surgery at American Surgical Centers regarding my Patient Rights and Responsibilities, Notice of Privacy Practice, Patient Complaints, HIPAA, Advance Directives and Ownership in the surgery center. I will read this information and direct any question to the number provided on the brochure.

☐Patient ☐Parent of Minor ☐Legal Representative

Name (please print)	Date
Signature	Witness