

SURGERY CENTER OF SANTA MONICA

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. The Surgery Center of Santa Monica 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 Surgery Center of Santa Monica for clarification.

Patient Signature

Date