LAKE RIDGE
AMBULATORY SURGERY CENTER, LLC

ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

PATIENT RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES, PHYSICIAN OWNERSHIP DISCLOSURE, AND PATIENT GRIEVANCE INFORMATION

I understand that Lake Ridge Ambulatory Surgery Center, LLC and Capital Anesthesia Services may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, I have been offered, or I have received in the past, a copy of the Notice of Privacy Practices for the center, which provides information regarding how the center, and individuals involved in my care at the center, may use and disclose my protected health information. I acknowledge that I have received and/or have been offered a copy of the Lake Ridge Ambulatory Surgery Center "Notice of Privacy Practices" with the effective date of 6/10/2016.

PATIENT RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES, PHYSICIAN OWNERSHIP DISCLOSURE, AND PATIENT GRIEVANCE INFORMATION

I acknowledge that I have received verbal and written notice of the Patient Rights & Responsibilities, Advance Directives, Physician Ownership Disclosure and Patient Grievance information from Lake Ridge Ambulatory Surgery Center on the day of my procedure.

I have an Advanced Directive (health care surrogate, living will, durable power of attorney for health care): ☐ **Yes** ☐ **No.**

If a copy is provided, this will remain in your medical record and accompany you to the hospital should a transfer be necessary.

Lake Ridge Ambulatory Surgery Center Physician Owner: ☐ **Yes** ☐ **No**

Acknowledgement and Understanding of Information Provided

X_____ Signature of Patient / Personal Representative

X_____ Date

X_____ Relationship to Patient

X_____ Print Patient's Name

X_____ Staff Signature

X_____ Date

For Staff Use Only

The above-named Patient/Personal Representative was provided with a copy of the "Notice of Privacy Practices." A good faith effort was made to obtain a written acknowledgment of his/her receipt of the Notice, but such acknowledgment could not be obtained because:

___ Patient/Personal Representative refused to sign.

___ Patient/Personal Representative was unable to sign or initial because:

Staff Signature: _____ Date: _____