ORLANDO CENTER FOR OUTPATIENT SURGERY

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 Orlando Center for Outpatient Surgery 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 for clarification.

_____ _____

Patient Signature Date

1405 South Orange Avenue, Suite #400
Orlando, FL 32806
(407) 426-8331