

**PATIENT SELF-DETERMINATION ACT**

At the time of admission, does the patient have an **Advance Directive** (i.e. Durable Power of Attorney for Health Care, a Living Will, or a California Declaration)?

- No     Patient is a Minor or Child
- Yes     Copy is Provided, in Chart     No Copy Provided to Center

**PATIENT ACKNOWLEDGES:**

I have received information, if desired, concerning an individual's rights under state law (statutory or recognized by the courts of the state) to make decisions concerning health care, including the right to accept or refuse health care and the right to formulate advance directives.

I acknowledge that prior to my procedure I have either received from my physician's office, or reviewed on Coast Surgery Center's web-site, information regarding **Patient Rights and Responsibilities**, the center's **Advance Directive Policy** and information on physician **Ownership Interest**.

I acknowledge that I have received a copy of the Privacy Notice for Coast Surgery Center.

Privacy Notice Revised: April 14, 2003

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility Representative

**CENTER USE ONLY**

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, *acknowledgement has not been obtained* because:

- Patient refused to sign the Privacy Notice Acknowledgement
- Patient was unable to sign because:

\_\_\_\_\_

- Other reason, described below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**COAST SURGERY CENTER**

Patient Acknowledgement