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

Information has been made available to me 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 understand that due to the elective nature of my visit to this surgery center, any advance directives I may have in place will be placed on hold while in the care of this center. _________
(Patient Initials)

INFORMATION ACKNOWLEDGEMENT

I acknowledge that prior to my procedure I have either received from my physician's office or have reviewed on Pacific Endo-Surgical Center's website, information regarding **Patient Rights and Responsibilities**, the center's **Advance Directive Policy**, the ability of a patient to report a **Grievance**, and information on **Physician Ownership Interest** at Pacific Endo-Surgical Center.

I acknowledge that I have received a copy of the **Privacy Notice** for Pacific Endo-Surgical Center.

_______________________________ _______________________
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

PATIENT'S PREFERENCES REGARDING THEIR PROTECTED HEALTH INFORMATION

Telephone Communication Preferences

Location	May we call you here?		May we leave a message?	
Home	☐ Yes	☐ No	☐ Yes	☐ No
Work	☐ Yes	☐ No	☐ Yes	☐ No
Mobile Phone	☐ Yes	☐ No	☐ Yes	☐ No
Other_____________________	☐ Yes	☐ No	☐ Yes	☐ No

Mail Communication Preferences

May we send mail to your home address? ☐ Yes ☐ No
(If no, please provide an alternate mailing address below.)

____
____
____

Other than you, your insurance company, and health care providers involved in your care, whom may we talk with about your health care information? (Check all that apply)

	Name	Telephone
☐ Spouse	_____________________________	_____________________
☐ Caretaker	_____________________________	_____________________
☐ Child	_____________________________	_____________________
☐ Parent	_____________________________	_____________________
☐ Other	_____________________________	_____________________

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

____
____
____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

____________________________________ ______________________
Patient or Legal Representative Signature Date

____________________________________ ______________________
Printed Name Relationship if NOT Patient