ACKNOWLEDGEMENT OF RECEIPT OF NOTICE: PLEASE REVIEW THIS ACKNOWLEDGEMENT AND SIGN BELOW AFTER YOU HAVE RECEIVED THE INFORMATION THAT HAS BEEN CHECKED ON THE LIST SHOWN BELOW

Patient Name: _____ Date: _____

ACKNOWLEDGEMENT: PATIENT TO PLACE INITIALS IN SPACES BELOW AS INDICATED

_____ (Init) I acknowledge that I have received and/or read and been offered a copy of the following:
NOTICE OF PRIVACY PRACTICES AND RIGHTS – I have read the notice and I understand my privacy rights and the privacy office's policies.

PATIENT AUTHORIZATION & RESPONSIBILITY FORM

PATIENT BILL OF RIGHTS – I have read the notice and I understand my patient rights

_____ (Init) I acknowledge that I have received and/or read or have been given an explanation of the **following prior to admission**:

ADVANCE DIRECTIVE:
( ) I do have an advanced directive. Do you have it with you? ( ) Yes ( ) No

( ) I do **not** have an advanced directive

( ) Patient given a copy of the states advance directive form and additional information including state website:
http://www.tha.org/GeneralPublic/AdvanceDirectives/WhatareMyOptionsfor09C0.asp

( ) Patient did not wish to have the form provided by the state, nor further Information regarding advanced directives.

DISCLOSURE OF OWNERSHIP: In accordance with Federal ASC Regulations (42 C.F.R 416.50(a)(ii), the following disclosure is made in advance of the procedure:

Altus Healthcare Management Services is owned in part by physicians who practice medicine in the area. The physician who will be performing your procedure might be an owner.
By signing below, you or your legal representative, acknowledge that this disclosure has been made in advance of the date of the procedure, and that you have decided to have the procedure performed at Altus Healthcare Management Services The physician who refers you to our facility may have an ownership interest in this facility. You are free to choose another facility in which to receive services.

_____(√) Patient refuses to sign the notices. Employee name and date: _____

_____(√) The patient is unable to sign the acknowledgement or is a minor. If the patient is a minor or represented by a personal representative; the authorized guardian/representative has signed below.

Patient/Responsible Person:_____ **Date:**_____

Witness: _____ **Date:** _____

ALTUS™ HOSPITAL

Patient Label

ACKNOWLEDGEMENT FORM