

*Please fax to (352) 333-4564 and keep original for office chart  
(Or the patient may bring a copy with them to pre-admit appointment)*

Patient Name: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

- **Rights and Responsibilities:**

I have been informed of my rights and responsibilities as a patient of the North Florida Surgical Pavilion and have received a brochure listing these rights and responsibilities.

- **Disclosure of physician ownership in the Surgical Pavilion:**

We are required by law to inform you about the ownership of our facility and alternative providers of similar services. Local alternative providers include but are not limited to North Florida Regional Medical Center, various ambulatory surgery centers, and Shands Hospital. North Florida Surgical Pavilion is jointly owned by North Florida Regional Medical Center and a group of private investors. A number of physicians are members of this investor group.

Your physician, Dr. \_\_\_\_\_ is \_\_\_\_ is not \_\_\_\_ an investor.

- **Information and facility policy concerning Advanced Directives:**

Unlike in an acute care hospital setting, North Florida Surgical Pavilion does not routinely perform “high risk” procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

Therefore, it is our policy, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at North Florida Surgical Pavilion we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power if attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

***BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND ACKNOWLEDGE RECEIPT OF THE ABOVE INFORMATION.***

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Patient Signature / Parent or Guardian if Minor)

\_\_\_\_\_  
(PRINT NAME)