# ACKNOWLEDGMENT OF RECEIPT

I acknowledge that prior to the scheduling of my procedure(s) I was given a copy of the Patients Rights and Responsibilities, and that the following information has been disclosed to me:

1. Advance Directives Policy:
   "Advance Directives are not honored at the Facility and that in the event of an emergency or life threatening situation, advanced cardiac life support procedures will be instituted in every instance and that I will be transferred to a higher level of care."

2. That my physician may have an ownership interest in NovaMed Surgery Center of Merrillville, and that I have the option of being treated at another facility.

_______________________________________ ________________________

Patient (or Personal Representative) Signature Date

______________________________

Patient Name or Patient Data Sticker

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _______________________________

______________________________

Witness