RECEIPT OF INFORMATION FROM BLOOMFIELD HILLS SURGICAL CENTER

I acknowledge receipt of information prior to my date of surgery at Bloomfield Hills Surgical Center regarding my Patient Rights and Responsibilities, Notice of Privacy Practice, Patient Complaints, HIPAA, Advance Directives and Ownership in the surgery center. I will read this information and direct any question to the number provided on the brochure.

_____ _____

Name (please print) Date

_____ ☐Patient ☐Parent of Minor ☐Legal Representative

Signature

_____

Witness