EMERALD COAST SURGERY CENTER

an affiliate of WHITE-WILSON MEDICAL CENTER, P.A.

ASC Conditions of Coverage Patient Attestation

Patient Name: _____ **Date of Procedure:** _____

I certify that I have received written documentation of the following items, in advance of the date of my scheduled procedure:

1. Patient's Rights and Responsibilities

2. The Emerald Coast Surgery Center policy concerning Advance Directives

3. Disclosure of Physician Ownership

Furthermore, I understand that this information is being provided for my benefit and that should I have any questions regarding its content, I should contact The Emerald Coast Surgery Center for clarification.

_____ _____

Patient Signature Date

Please bring this attestation to the Emerald Coast Surgery Center on day of surgery or before.

995 MAR WALT DRIVE, FORT WALTON BEACH, FL 32547
850-863-7887