MISSION HILLS SURGICENTER
25982 PALA #280
MISSION VIEJO, CA 92691

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES:

I have received a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities.

_____ _____

Please print your name **Signature**

ADVANCE DIRECTIVES (LIVING WILL):

Due to the elective nature of the procedures performed, Mission Hills Surgicenter does not honor advance directives. However, if it becomes necessary to transfer you to a hospital for further care, your advance directive can be sent with you to the hospital. Please let us know if you have executed an advance directive.

I have an advance directive _____I don't have an advance directive_____
Are you providing a copy of your advance directive ___**YES** ___**NO**

DISCLOSURE STATEMENT

Your Physician, _____ has scheduled you for a procedure at Mission Hills Surgicenter where he has a financial interest. Mission Hills Surgicenter also wishes to make you aware of the fact that there are other facilities in our medical community where the same procedure(s) can be performed. By signing below you acknowledge understanding your right.

I hereby acknowledge that I have received information about my Physician's ownership in the facility as well as information about the Advance Directive Policy at Mission Hills Surgicenter. I have also received a copy of the Patient Rights and Responsibilities and Grievance Policy.

Thank you.

_____
Signature

Date: _____

_____
Please print your name