Hillside ASC, LLC

Certification of Understanding

By my signature, I ________________________________, certify the following:
(Please print patient's name)

Certification of Patient Rights

That Hillside ASC, LLC notified me in advance of my Patient Rights and furthermore, I have read and understand.

Authorization and Payment Guarantee

That Hillside ASC, LLC notified me in advance of information pertaining to Release of Information, Benefits Assignment, Payment Guarantee, Authorization to Obtain Credit Bureau Report, Acknowledgements and furthermore, I have read and understand.

Disclosure of Physician Ownership
Certification of Disclosure of Physician Ownership

That Hillside ASC, LLC notified me in advance of physician ownership/financial interest, I have read and understand.

☐ I choose another facility
☐ I choose Hillside ASC, LLC

Certification of Advanced Directives

☐ That **I Do Not Have** Advanced Directives
☐ That **I Do Have** Advanced Directives

And furthermore, Hillside ASC, LLC notified me in advance of their policy regarding Advance Directives.

______________________________________ ______________________
Patient's Signature/Authorized Patient Representative *Date*

______________________________________ ______________________
Please Print - Patient's Signature/Authorized Patient Representative *Relationship to Patient*