Montgomery Surgery Center

PATIENT ATTESTATION FORM

Patient Name: _____

I have been given a copy and have read my rights and responsibilities as a patient of Montgomery Surgery Center. I am aware that my physician may have a financial interest or ownership in the center. In addition, I have received the facility policy on advanced directives and a description of the applicable State Health and Safety Laws related to advance directives, as well as information on how to file a grievance or complaint if necessary.

Patient Signature: _____ Date:_____