UROLOGY SURGERY CENTER OF SAVANNAH, L.L.L.P.
PATIENT DISCLOSURES

ADVANCE DIRECTIVES

Urology Surgery Center of Savannah is an outpatient surgery center that is limited to elective surgery only and performs no high-risk surgical procedures. It is the policy of Urology Surgery Center of Savannah to recognize the patient's Health Care Agent in the event circumstances require a patient to be transferred to a hospital. Urology Surgery Center will not acknowledge DNR (Do Not Resuscitate) orders on any patient while in this surgery center. I hereby acknowledge this statement and have indicated my understanding by signing below.

☐ I have ☐ I have not made an Advance Directive or
☐ I do not have an Advance Directive and do not want to make one at this time.

COMMUNICATION AUTHORIZATION

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner. You may leave messages with, discuss my treatment, appointments or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that Urology Surgery Center of Savannah will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers. Please List below those individuals with whom you authorize our office to discuss aspects related to your care.

Name _____ **Relation to Patient:** _____

Name _____ **Relation to Patient:** _____

Name _____ **Relation to Patient:** _____

You are also provided the right to request confidential communications of your protected health information be made by alternative means, such as sending correspondence to your office instead of your home.

I wish to be contacted in the following manner: (check all that apply)

☐ Home telephone ☐ Okay to leave message with detailed information ☐ Leave message with call back number

☐ Work telephone ☐ Okay to leave message with detailed information ☐ Leave message with call back number

☐ Written ☐ mail to my home address ☐mail to my work/office address

ACKNOWLEDGEMENT OF RECEIPT

By signing below, I acknowledge that I received a copy of the following notices prior to my scheduled procedure.

- Patient Rights/Responsibilities both verbal and written
- Disclosure of Physician Ownership of the Ambulatory Surgery Center
- Grievance Process and who to contact, if necessary
- Privacy Notice

This information was verbally explained to me and I received a written copy to review prior to my procedure. I was also given a chance to ask questions regarding this information. A copy of this information was also available for me to download and print from the Urological Associates of Savannah website (www.urologysavannah.com).

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____