Carolina Specialty
EYE SURGERY CENTER

Patient Notification and Acknowledgement

Notice of Rights
Carolina Specialty Eye Surgery has established a Patient's Bill of Rights, which is provided verbally and in writing in a language and manner the patient or patient's representative understands prior to the date of the procedure. Carolina Specialty Eye Surgery expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the facility.

Financial Disclosure
Carolina Specialty Eye Surgery is privately owned and has informed the patient prior to the date of the procedure that their physician may have a proprietary interest in this facility. The patient has the right to choose the facility of his/her choice for health-related services.

Advance Directives
Because the scope of Carolina Specialty Eye Surgery is limited to elective outpatient surgical procedures, it is the policy of this facility, that any life-threatening situation that arises will be immediately treated with life-sustaining measures. Concurrently, the emergency medical system (EMS) will be activated for emergency patient transport to a hospital facility. The patient's right and need to be an active participant in the decision-making process regarding their care is recognized and respected. Acknowledgement of this policy does not revoke or invalidate any current health care directive or health care power of attorney.

Please check the appropriate box. Have you executed an advance health care directive, a living will and/or a power of attorney that authorizes someone to make health care decisions for you?

☐ **Yes**, I have an advance health care directive, living will and/or a power of attorney.
☐ I have provided a copy of my advance health care directive, living will and/or a power of attorney.
☐ **No**, I do not have an advance health care directive, living will and/or a power of attorney.
☐ I would like additional information on advance health care directives.

By signing this document, I acknowledge that the above information was given to me prior to my day of surgery, and that I have read and understand the information on notice of privacy practices, patient rights, financial disclosure and advance directives. I agree to the policies of Carolina Specialty Eye Surgery. If I have indicated I would like additional information, I acknowledge receipt of that information.

_____ _____
Patient Signature (If patient is unable to sign, please indicate relationship) Date

_____ _____
Witness Signature Date

Patient Acct# _____