Euclid Endoscopy Center

ASC Conditions of Coverage Patient Attestation

Patient Name:_____ Date of Procedure:_____

I certify that I have received written documentation of the following items, in advance of the date of my procedure:

1. Patient's Rights and Responsibilities
2. The Euclid Endoscopy Center policy concerning Advance Directives
3. The Euclid Endoscopy Center Non-Discrimination policy
4. Disclosure of Physician Ownership
5. HIPPA

Furthermore, I understand that this information is being provided for my benefit and that should I have any questions regarding it's content, I should contact the Euclid Endoscopy Center for clarification.

_____ _____

Patient Signature **Date received**

****Please return this page to Euclid Endoscopy Center***