

**GROSSMONT SURGERY CENTER**

*an affiliate of* **SCA**

**PATIENT ATTESTATION**

ASC Conditions of Coverage

**Patient Name:** \_\_\_\_\_

**Date of Procedure:** \_\_\_\_\_

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

- 1. Patient’s Rights and Responsibilities
- 2. Grossmont Surgery Center policy concerning Advance Directives
- 3. Disclosure of Physician Ownership
- 4. Medical History Form.
- 5. Medication Form.

I understand that this information is being provided for my benefit. Should I have any questions regarding its content, I should contact Grossmont Surgery Center for clarification.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

If patient is a minor or unable to sign complete the following:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date

**IMPORTANT: PLEASE REVIEW ALL ENCLOSED MATERIAL AND SIGN THIS FORM PRIOR TO YOUR DATE OF SURGERY.**

**PLEASE BRING THIS FORM ALONG WITH:**

- Photo Identification
- All active medical insurance cards.
- Completed Medical History form.