PATIENT NOTIFICATION AND ACKNOWLEGDEMENT

I hereby certify that I received the information below verbally and in writing in advance of the date of my procedure.

Financial Disclosure

Seattle Spine Institute (SSI) 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.

Privacy Notice

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the health insurance Portability & Accountability Act of 1996 (HIPPA). In addition, I've been afford a copy Acknowledgement of Privacy Practices.

Notice of Rights

SSI 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. **SSI** expects that observance of these rights will contribute to more effective patient care and greater satisfaction for patients, physicians and the facility.

Advance Directives

It is the policy of **SSI**, regardless of any advance directives or instructions from a health care surrogate or power of attorney, that an unexpected medical emergency, which occurs during treatment at this facility, will be aggressively managed with resuscitative or other stabilizing measures followed by emergency transfer to the closest emergency room. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or health care power of attorney. 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 my advance health care directive, living will and/or a power of attorney to Seattle Spine Institute.

☐ **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 patient rights, financial disclosure and advance directives. I agree to the policies of **SSI**. 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