

# CERTIFICATION OF UNDERSTANDING

By my signature, I \_\_\_\_\_, the patient, certify the following: (please print)

## Certification of Patient Rights

That Andrews Institute ASC, LLC notified me in advance of my Patient Rights furthermore, I have read and understand.

## Disclosure of Physician Ownership

### Certification of Disclosure of Physician Ownership

That Andrews Institute ASC, LLC notified me in advance of physician ownership/financial interest, I have read and understand.

I choose another facility.

I choose Andrews Institute Surgery Center.

## Certification of Advanced Directives

That **I DO NOT HAVE** an Advanced Directives.

That **I DO HAVE** an Advanced Directives and furthermore, Andrews Institute ASC, LLC notified me in advance of their policy regarding Advanced Directives.

\_\_\_\_\_  
Patient's Signature or  
Authorized Patient Representative

\_\_\_\_\_  
Date

Above discussed with patient/responsible party during PAT call:

\_\_\_\_\_/\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
RN Signature