PSI SURGERY CENTER, LLC.

RECEIPT OF NOTICE OF PATIENT RIGHTS AND ADVANCED DIRECTIVES FORM

☐ Provided a written copy of my Patient Rights.

☐ Provided a copy of PSI Surgery Center LLC.'s policy and Ohio law regarding Advanced Directives.

☐ I do not have an Advanced Directive.

☐ I have an Advanced Directive

TYPE:

□ Health Care Power of Attorney

□ Living Will

□ Do Not Resuscitate

☐ Copy of Advanced Directive placed on chart.

☐ Signed waiver to rescind Advanced Directive during procedure.

___________________________________/__________________________/______________

Patient or Person Authorized to Sign for Patient Print name Date

__________________________________/____________________________/______________

Witness Print name Date