Patient Responsibilities: The patient has the responsibility to do the following:

I. The patient is encouraged to ask any and all questions to the physician and staff in order that he/she may have a full knowledge of the procedure and aftercare

II. Follow the treatment plan prescribed by his/her provider and participate in his/her care.

III. Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.

IV. Provide the organization with information about their expectations of and satisfaction with the organization.

V. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.

VI. Inform his/her provider about an living will, medical power of attorney, or other directive that could affect his/her care.

VII. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy.

VIII. Supply insurance information and pay bills promptly so that the Surgical Center at Cedar Knolls can continue to serve you effectively.

IX. Accept personal financial responsibility for any charges not covered by his/her insurance.

X. Be respectful of all the health care providers and staff, as well as the other patients.

Patients Signature	**Date**
Witness	**Date**

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the Notice of Privacy Policies for the groups listed above, detailing how my Protected Health Information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse, guardian)

Relationship: Witnesses by:

I, _____ authorize The Surgical Center at Cedar Knolls LLC, to release my medical information to :

_____

_____

_____

Internal Use Only:If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):_____By: (name and title):_____