

**South Broward
Endoscopy**

11011 Sheridan Street, Suite 106
Cooper City, FL 33026
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ACKNOWLEDGEMENT OF CONDITIONS FOR COVERAGE

I, _____ will be undergoing Endoscopic procedure(s) on or about _____, 20____ and hereby affirm that I have been provided with, and have had the opportunity to read and ask questions concerning the following information contained in the Patient Information brochure from South Broward Endoscopy, an Ambulatory Surgical Center:

- Patient's Rights and Responsibilities;
- Notice of Policy Regarding Advance Directives; and
- Notice of Disclosure of Ownership Interest

I understand that any questions concerning the necessity or appropriateness of the proposed surgical procedure(s) to be performed, as well as any available alternative treatment techniques have been discussed with me by my physician.

Patient Signature

Date

Witness

Date

WBS DSW BM JBK AL CAG LSM

NOTE TO SCHEDULERS:

Please have the patient sign this form and attach it to booking sheet and fax to South Broward Endoscopy *prior* to date of procedure