NAME OF ASC

DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in this notice.

1. ____name of ASC___ meets the definition of a "physician-owned ambulatory surgery center" under 42 Code of Federal Regulations §416. The ambulatory surgery center is owned in part by the following physicians.

   _____

   _____

   _____

2. You have the right to choose the provider of your health care services. Although we believe that ____name of ASC___ will be able to meet your needs, you have the option to use a facility other than ____name of ASC___. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedures at an alternative facility if he does not maintain privileges at such facility. If desired, your physician or any staff member can provide information about alternative health care providers.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of ____name of ASC___. We welcome you as a patient and value our relationship with you.

Signing below means that you have received and understand this notice.

Signature:	**Date:**