Acknowledgment of Receipt Privacy Notice

I understand that the Culpeper Surgery Center, LLC and Culpeper Anesthesia Concepts LLC may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered or have received in the past a copy of the Notice of Privacy Practices for the Facilities, which provides information about how the Facilities and individuals involved in my care at the Facilities, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, please contact the Privacy Officer at 540-829-0700.

I acknowledge that I have received the Privacy Notice.

_____ _____

Patient or Personal Representative Signature **Date**

Acknowledgement Receipt of Patients Rights, Advance Directive and Physician Ownership Disclosure.

I acknowledge that I have received verbal and written notice of Patient Rights & Responsibilities, Advance Directive policy and Physician Ownership Disclosure from Culpeper Surgery Center in advance of the date of my procedure.

_____ _____

Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____