MELBOURNE SURGERY CENTER
an affiliate of SCA

ASC Conditions of Coverage Patient Attestation

I _____(print name) certify that I have reviewed on-line, at www.melbournesurgerycenter.com and/or received documentation of the following items, in advance of the date of my scheduled procedure. In addition, Notice of Patient's Rights and Responsibilities were provided verbally.

1. Patient's Rights and Responsibility
2. Melbourne Surgery Center policy concerning Advance Directives
3. Physician Ownership Disclosure Statement
4. Anti-Discrimination Policy

Furthermore, I understand that this information is being provided for my benefit and that should I have any questions regarding its content, I should contact Melbourne Surgery Center for clarification.

Disclosure Statement

We are delighted that you and your physician have chosen the Melbourne Surgery Center for your surgery needs. We are grateful for the opportunity to serve you.

As per Florida Law, all Ambulatory Surgery Centers are required to inform you of any physician investment in the facility and to notify you of alternative facilities available to you. Please view the information provided below.

Alternate Facilities:

Healthfirst Medical Center 1350 S. Hickory St Melbourne, FL 32901	Palm Bay Community Hospital 1425 Malabar Rd Palm Bay, FL 32907	Melbourne Regional Med Ctr 250 N. Wickham Rd Melbourne, FL 32935

Melbourne Surgery Center Physician Investors:

Dr. John Hermansdorfer	Dr. Steven Ho
Dr. Robert Tinsley	Dr. Gonzalo Valdivia
Dr. Marja Sprock	Dr. Regine Pappas
Dr. John Olinde	Dr. David Malis
Dr. Aleksander Komar	Dr. Mark Hanley

Your signature below will confirm that you have been made aware of physician ownership interest in this facility, and that you have been provided names and address of alternative facilities should you choose to use them.

_____
Patient Signature and Date

** Please complete, sign, date and return this form to the facility on the date of surgery or in advance via fax at (321) 768-6043.