ROCHESTER SKIN CANCER CENTER / ROCHESTER SURGERY CENTER P.C.

IMPORTANT NOTICES

Patient rights and responsibilities

Our Surgical Facility's policy on Patient Rights and Responsibilities is sent to our patients with our surgery brochure prior to surgery. Additional copies are available at any time, and we will be happy to answer any questions or discuss any component of these rights and responsibilities.

Financial Interest Disclosure

Dr. David R. Byrd has a financial and ownership interest in the Surgical Facility. By consenting to have your surgery at our Surgical Facility you acknowledge that you have elected to have your procedure performed at the Surgical facility after considering both the physician's financial interest in the Surgical Facility and your choice to have the procedure performed at a different facility.

Advance Directives

Advance directives are legal documents that allow individuals to convey decisions about end-of-life care ahead of time. They provide a way for an individual to communicate his or her wishes to family, friends, and health care professionals, and to avoid confusion later on.

Do you have Advance Directives? (i.e. Living Will or Medical POA) ___ Yes ___ No

Advance Directives Policy: Advance Directives do not apply during the time of the procedure at our Surgical Facility. All life saving measures will be taken during your procedure at our Facility even if you have a fully executed Advance Directive to the contrary. If you do have Advance Directives at the time of your admission to our Surgical Facility, and provide a copy, your Advance Directives will be placed on your record. In the unlikely event that an emergency arises, and you would need to be transferred to the hospital for further care, your Advance Directives will be sent with your chart to the receiving hospital.

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By my signature below, I acknowledge that I have been informed of the **Health Information Practices**, the **Policy on Patient Rights and Responsibilities**, and the **Facility Financial Interest Disclosure,** and that I have read, understand, and agree to the **Financial Policy**.

By my signature below I also acknowledge that I have received the **Advance Directives notices** provided by the Surgical Facility prior to the date of my procedure, or if my procedure has been scheduled the same day as my referral, I have received the notices prior to the Surgical Facility obtaining informed consent for the procedure to be performed.

Signature_____ Date _____

Print Name _____ Time_____
(Complete time only if receiving the Mohs Pamphlet on the same day as the procedure)
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