Brandon Ambulatory Surgery Center

Notification to our patients

Dear Patients:

The enclosed information is being supplied to every patient who accesses our surgery center. We are required to provide you with the attached information both written and verbally. Please read the following carefully and indicate with your signature that you have been provided this information on the date indicated.

1. I have reviewed and understand the patient rights and responsibilities associated with my visit to the Brandon Ambulatory Surgery Center.

2. I understand that if I currently have advanced directivves they will be suspended for the period of time that I am treated in the center. If I require additional care in the hospital my advance directives will be in effect for that care. **YOU MUST BRING A COPY OF YOUR ADVANCE DIRECTIVE WITH YOU ON THE DAY OF YOUR PROCEDURE.** If I do not have advanced directives I have been offered information to create my own advance directive.

3. I understand that my Doctor _____ is an owner and has a financial interest in the Surgery Center. If this is marked N/A my physician does not have an interest in the Center.

_____ _____

Signature of Patient Date: (date patient received)

_____ _____

Signature of Responsible Party Relationship to patient

Important Document

Please remember to bring this with you on your surgery day.
Or fax to: 813-571-7099 from the office or home

Thank you in advance for making us your provider of choice!

514 Eichenfeld Drive • Brandon, Florida 33511 • Phone: 813.571.7088 • Fax: 813.571.7099