DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Your physician, _____, is an owner of and has interests in The Medical Center at Elizabeth Place.

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than The Medical Center at Elizabeth Place

3. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than The Medical Center at Elizabeth Place.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of our office at The Medical Center at Elizabeth Place. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in The Medical Center at Elizabeth Place

_____ _____

Signature of Patient Type / Print Name of Patient

_____ _____

Signature of Parent / Guardian (if applicable) Type / Print Name of Parent/Guardian (if applicable)

Dated: _____