

StDavid's | **NORTH AUSTIN
SURGERY CENTER**

Date: _____

Patient: _____
(Please print your full name.)

DOB: _____

Contact # (provided by patient): _____
(Please provide the best number to reach you at.)

ACKNOWLEDGEMENT

I hereby acknowledge that I have received from my doctor's staff, the North Austin Surgery Center Pamphlet which includes the Patient's Rights and Responsibilities insert. I am aware that someone from North Austin Surgery Center will be contacting me to confirm that I received this information.

I understand that if North Austin Surgery Center is unable to speak with me before the day of my procedure, my procedure will have to be canceled and rescheduled – even if procedure prep has been done.

Patient Signature

Date

Doctor's Office Staff Signature

Date