

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE,
PATIENT RIGHTS, AND POSITION ON ADVANCED
DIRECTIVES.**

* I acknowledge that I have received a copy of the **Privacy Notice** that is part of Carbon-Schuylkill Endoscopy Center's policies.

Patient or Personal Representative Signature

Date

* I acknowledge that I have received a copy of **Patient Rights** that is part of Carbon-Schuylkill Endoscopy Center's practices.

Patient or Personal Representative Signature

Date

* I acknowledge that I have received a copy of Carbon-Schuylkill Endoscopy Center's policy stating that **Advanced Directives are not honored** while at this facility. And that I may request to review the policy at this time and have had the opportunity to ask questions.

Patient or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.
