



This notice is to inform you of your rights as a patient at the Center regarding the following topics:

- ◆ **Advance Directives:** Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If a patient or patient's representative wants their Advance Directive to be honored, the patient will be offered care at another facility that will comply with their wishes.
- ◆ **Physician Financial Interest and Ownership:** The Center is owned by physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.
- ◆ **Submission and Investigation of Grievances:** You have the right to submit a verbal or a written grievance, have it investigated and to receive a written notice of the Center's decision. The following are the names and/or agencies you may contact:
 - Vivian DiCarlo, RN, Center Director 12700 Creekside Lane, Suite 202 Fort Myers, FL 33919 Telephone: 239-489-4454
 - Agency for HealthCare Administration- Facility Regulation -Compliance 2727 Mahan Drive, Tallahassee, FL 32317-4000
State website: www.fdhc.state.fl.us
 - Medicare: www.medicare.gov or call 1-800- 633-4227
 - Office of the Inspector General: <http://oig.hhs.gov>
 - Medicare Ombudsman website: www.medicare.gov/Ombudsman/resources.asp
 - Your state representative: www.cdc.gov/mmwr/about.html
 - Medicare Quality Improvement Organization of Florida: FMQAI 5201 West Kennedy Boulevard, Suite 900 Tampa, Florida 33609
Attention: Beneficiary Complaints Phone: 800-844-0795. Web address: <http://www.fmqai.com/Complaint.aspx>

By signing below, you or your legal representative acknowledge you have received (verbally and in writing), read and understand this information prior to the procedure and have decided to have your procedure performed at this center.

_____ Date

_____ Patient Signature