BERGEN-PASSAIC
CATARACT SURGERY & LASER CENTER, INC

CfC Information Packet Acknowledgement Form

Patient Name _____

The patient, or person signing for the patient named above, acknowledges receipt of the following information in advance of the date of surgery unless referral to the ASC for surgery is made on that same date; and the referring physician indicates, in writing, that it is medically necessary for the patient to have the surgery on the same day, and that surgery in an ASC setting is suitable for that patient.

£ Advance Directive Policy

£ Patient Rights Statement

£ Notice of Privacy Practices

Authorization To Disclose PHI

Bergen-Passaic Cataract Surgery and Laser Center, Inc is authorized to disclose PHI relevant to my care and/or payment for my care to the person(s) named below.

Print Name of Person to whom the center may disclose PHI	Relationship
Print Name of Person to whom the center may disclose PHI	Relationship

Signature of Patient/ Guardian **Date**

Printed Name of Patient/Guardian If other than patient indicate relationship