ALASKA SPINE CENTER

an affiliate of SCA

# ASC CONDITIONS OF COVERAGE PATIENT ATTESTATION PHYSICIAN DISCLOSURE STATEMENT

Dear Patient:

We are delighted that you have chosen the Alaska Spine Center for your elective procedure.

We want to verify that as the patient, you have received written documentation of the following items, in advance or on the date of my scheduled surgery:

**Patient's Rights and Responsibilities**
**Advance Directives**
**Disclosure of Physician Ownership**

In addition, due to physician investment in this facility, it is required by Alaska State law that we notify you of the alternative facilities available to you.

**Providence Hospital**
3200 Providence Dr.
Anchorage, AK 99508
(907) 261-3049

**AK Regional Hospital**
2801 Debarr Rd
Anchorage, AK 99508
(907) 276-1131

**Creekside Surgery Center**
3831 Piper Street
Anchorage, AK 99508
(907) 339 7800

Your signature below confirms that you have been made aware of your physician's approximate 1% ownership interest in this facility, and that you have been provided names and address of alternative facilities should you choose to use them.

Furthermore, I understand that this information is being provided for my benefit and that should I have any questions regarding its content, I should contact the Center for clarification.

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**Patient Signature** **Date**