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PATIENT DISCLOSURE FORM

Date:

Patient name: ______________________________

Dear patient,

At the time of scheduling, we offer one of four facilities for your convenience listed below:

St. Vincent hospital – Indianapolis
St. Vincent hospital – Carmel
Riverview hospital
Carmel Ambulatory Surgery and Endoscopy Center

As you have selected to have your outpatient procedure at the Carmel Ambulatory Surgery and Endoscopy Center, Dr. Erdel and Dr. Fecht are required under Indiana law to disclose to you that they have a financial interest in the facility you have chosen.

By signing below, I acknowledge that I have been informed by Dr. Erdel and Dr. Fecht's staff of their financial interest in the Carmel Ambulatory Surgery and Endoscopy Center and that I have been given the choice of another health care facility for treatment.

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Patient / authorized representative signature

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Printed name   Relationship if other than self