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## PATIENT DISCLOSURE FORM

Date:

Patient name:

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Dear patient,

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

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

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

By signing below, I acknowledge that I have been informed by Dr. Fecht's staff of his 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