MILWAUKEE
SURGICAL SUITES

TRANSPORTATION RELEASE: I understand that the anesthetic to be administered to me may have effects that make it hazardous for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. I understand that MILWAUKEE SURGICAL SUITES will not perform my schedule procedure unless these arrangements are met, and have provided MILWAUKEE SURGICAL SUITES] with my designated responsible party's name and phone number. The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.

Responsible Party Name: _____ Phone# _____
(Person Driving Home)

Patient Signature: _____ Date: _____

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at MILWAUKEE SURGICAL SUITES and I understand that the center policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact) is to initiate resuscitative measures, should an adverse event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney. Please check one of the following:

- ○ **YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record**
- ○ **YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me**
- ○ **NO, I do not have an Advanced Directive/Living Will/Health Care Proxy**
- ○ **I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy**

I hereby acknowledge I have received copies of all of my patient rights, assignment of benefits, financial responsibility information and authorizations and disclosures. I also acknowledge my financial responsibility was explained to me and I received copies of all my ESTIMATED costs. I also am aware of the copy given to me in my discharge folder of the 4 possible separate fees which include: facility fee, surgeon fee, anesthesia fee, and pathology (when needed by surgeon).

Patient Sticker

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____