

**La Peer Surgery Center, LLC**  
**Patient Disclosure Information**

To all of our patients:

If your treatment program requires a surgical procedure(s) Dr. \_\_\_\_\_ may perform the surgery at La Peer Surgery Center, which he/she has ownership in. The following information is required by the Federal Government to be presented to all patients before their surgery. Please review the following information and sign that you have received it.

I \_\_\_\_\_ have also received a copy of this information to take home.  
(PATIENT'S NAME)

Please call our office or the Surgery Center if you have any questions about the information contained, herein.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date