

# WEST NORMAN ENDOSCOPY CENTER, LLC

3101 W. Tecumseh Rd. suite 100

Norman, Ok 73072

405-364-5900

**\*Please read the attached two forms, then print this page and sign and date it and bring it with you on the day of your procedure\***

Dear Patient:

We look forward to your upcoming visit at West Norman Endoscopy Center. It is the policy of West Norman Endoscopy Center to notify you of the following information prior to your arrival at the center on your day of service:

1. Notice of Patient Rights and Responsibilities:  
(see attached form)
2. Center policy regarding Advance Directives and more information upon request (see attached form):

## ASC Conditions for Coverage Patient Attestation

Patient Name: \_\_\_\_\_ Date of Procedure \_\_\_\_\_

I certify that I have received written documentation of the above information in advance of the date of my scheduled procedure.

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 West Norman Endoscopy Center for clarification.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date