

## NOTICE OF DISCLOSURE OF INTERESTS

Provider's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_

Email Address: \_\_\_\_\_

The "Patient Self-referral Act of 1993" provides a patient of a health care provider licensed by the state of Georgia with certain rights when a health care provider refers the patient to another health care provider or entity for services. Prior to the referral, the health care provider must furnish the patient with a written disclosure of:

- 1) The existence of the health care provider's investment interest;
- 2) The name and address of each applicable entity in which the referring health care provider is an investor; and,
- 3) Inform the patient of the right to obtain the items and services for which the patient has been referred at the location or from the health care provider or supplier of the patient's choice, including the entity in which the referring health care provider is an investor, unless the patient right to choose is otherwise restricted by law.

In accordance with the "Patient Self-referral Act of 1993" and as is required by law (O.C.G.A. § 43-1B-5), this notice is to inform you that as a patient of Dr. \_\_\_\_\_ D.C., you may be referred to a different location, health care provider, or supplier for clinical laboratory services, pharmacy services, MRI, radiation therapy services, and/or x-ray or imaging services.

Note that Dr. \_\_\_\_\_, D.C. and his/her immediate family have a financial or investment interest with the following health care providers or suppliers:

_____	_____
_____	_____
_____	_____

As a patient, you have the right to obtain services from a provider or supplier of your choosing. If you are referred to one of the providers or suppliers identified above and would like other alternatives, you may ask the office staff to assist you with locating a provider or supplier best suited to your individual needs or make your choose to make your own selection.

By signing this notice you agree and accept that you have fully read and understand your rights as a patient to self-refer, as allowed by law, to a health care provider or supplier of your choosing, you have received a copy of the **Notice of Disclosure of Interests** and you have made a fully informed decision about your health care.

Patient Name (printed): \_\_\_\_\_

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

Signature of Guardian (if under the age of 18): \_\_\_\_\_

Date: \_\_\_\_\_