FLORIDA
ENT ADULT & PEDIATRIC, PA

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FELLOW AMERICAN ACADEMY OF OTOLARYNGOLOGY

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* 720 West Oak Street, Suite 101

OTOLARYNGOLOGY – HEAD & NECK SURGERY – EAR & SINUS SURGERY – FACIAL PLASTIC & SKIN CANCER SURGERY – THYROID SURGERY

PHYSICIAN/PATIENT DISCLOSURE FORM

Omar A. Fadhli M.D.
The "Physician"

During the course of your physician/patient relationship with the Physician, the Physician may at a future time refer you to either **Celebration Surgery Center**, which operates an ambulatory surgery center located at 410 Celebration Place, Suite 408, Celebration Florida 34747 or **Millenia Surgery Center** which operates an ambulatory surgery center located at 4901 S. Vineland Rd. Suite 150, Orlando Florida 32811. Together referred to as "the surgery centers".
In connection with any such referral, the Physician hereby advises you that the Physician has an investment interest in the surgery centers. Please be advised that you have the right to obtain the health care items and services for which the Physician refers you, at any location or from any ambulatory surgery center, hospital, provider or supplier of your choice, including the surgery centers.
* * *
I, the undersigned patient (the "Patient"), received this Physician/Patient Disclosure Form from the above-referenced Physician, and I read and understood the information contained in this Physician/Patient Disclosure Form. The Physician furnished me with this Physician/Patient Disclosure Form prior to the Physician's referral of me to the surgery centers.

_____
(Date)

_____ _____
(Name of patient) (Signature of Patient)

_____ _____
(Home Address of Patient) (Printed Name of Parent or Legal Guardian)

_____ _____
(City, State, Zip of Patient) (Relationship to Patient)

_____ _____
(Telephone Number of Patient) (Home Street Address of Parent of Legal Guardian)

I, the undersigned, am the parent, legal representative or guardian of the Patient. The Patient is either a minor or is not physically able or competent to sign this Physician/Patient Disclosure Form on his or her own behalf. I received this Physician/Patient Disclosure Form from the Physician, and I read and understood the information contained in this Physician/Patient Disclosure Form.
The Physician furnished me with this Physician/Patient Disclosure Form prior to the Physician's referral of the Patient to the surgery centers.
I hereby sign this Physician/Patient Disclosure Form on behalf of the Patient, and I swear that I am legally authorized and empowered to sign this Physician/Patient Disclosure Form on behalf of the Patient.

_____ _____
(Name of patient) (Signature of Parent or Legal Guardian)

_____ _____
(Home Address of Patient) (Printed Name of Parent or Legal Guardian)

_____ _____
(City, State, Zip of Patient) (Relationship to Patient)

_____ _____
(Telephone Number of Patient) (Home Street Address of Parent or Legal Guardian)