NOTIFICATION OF OWNERSHIP AND ADVANCE DIRECTIVES

Practice Administrator
9450 E Ironwood Square Dr.
Scottsdale, AZ 85258
Phone: (480) 551-0581
Fax: (480) 551-0585
www.anewbeautifulyou.com

DISCLOSURE OF OWNERSHIP INTEREST

This Facility is owned by **Dr. Corwin D. Martin**. This physician has become owner as a result of this commitment to quality healthcare and service to his patients. Please be advised of the following:

A schedule of typical fees for services provided by the facility is available at your request.

You have the right to choose where to receive services, including an entity in which your physician may have a financial relationship.

Two reasonable alternative sources of services available are:

1. Scottsdale Healthcare Shea Campus — Phone # 480-323-3000
   Address 9003 E. Shea Blvd.
2. Scottsdale Healthcare Thompson Peak Campus — Phone # 480-324-7004
   Address 7400 E. Thompson Peak Pkwy.

ADVANCE DIRECTIVES

In order to be in compliance with the **Arizona State Law** regarding advance directives, the Facility requires each patient prior to scheduled procedures to read and acknowledge the Facility position on advance directives.

Advance Directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury. There are many types of advance directives, but the two most common forms are:

Living Wills. These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions

Durable Power of Attorney for Health Care. This is a signed, dated, and witnessed paper naming another person as an individual's agent or proxy to make medical decision for that individual if he/she should become unable to make his/her own decisions.

In the event of a medical emergency or other life-threatening situation, resuscitation will be instituted in every instance and patients will be transferred to a higher level of care.

Any previously formulated advance directives will not be honored at the Facility. If for any reason you disagree with this policy, please discuss your concerns with your physician before arriving for your scheduled procedure.

I have read and acknowledge that the Facility does not honor Advance Directive.

Patient's Signature: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________

If the patient is unable to sign or is a minor, please sign.

Relative/Guardian's Signature: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________