



# IMPORTANT

***It is very important that you read the information included on this page. Should you have any questions discuss with your admissions representative or call 317-634-0920.***

Due to governmental requirements we are required to perform the following steps:

- Inform patients verbally and in writing of their patient rights
- Inform patients in writing of the financial interests and ownership of the Indiana Kidney Institute
- Inform patients in writing of The Indiana Kidney Institute's policy regarding Advance Directives

Please be aware that while you are a patient at The Indiana Kidney Institute, we acknowledge that you have the right to develop an Advanced Medical Directive and we will be happy to provide you with the information you need to accomplish this. During your procedure at The Indiana Kidney Institute, it is our policy that Advanced Medical Directives will be suspended. In the event of an emergency, resuscitative measures will be taken while you are a patient at the center.

Financial Interest and Ownership of The Indiana Kidney Institute is as follows:  
Nephrology and Internal Medicine, Inc.

It is our intention to provide outstanding service to our patients. If you have any concerns or complaints regarding your care, WE WANT TO KNOW. Please notify any staff member or your physicians of any concerns.



## NOTICE OF PATIENT RIGHTS AND OWNERSHIP

By signing this form, I am acknowledging that I have:

- Received verbal and written instructions of my patient rights
- Received written notification of the Indiana Kidney Institute's policy on Advance Directives while I am a patient at the center.
- Received information of financial interest and ownership of the Indiana Kidney Institute.
- The above items were provided to me *prior* to my procedure at the Indiana Kidney Institute
- My questions were answered to my satisfaction

\_\_\_\_\_  
Signature of Patient (or Healthcare Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Healthcare Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\*A copy of this written acknowledgement shall be place in the medical record.