

**METRO ATLANTA ENDOSCOPY, LLC**

RECEIPT OF  
PATIENT RIGHTS AND RESPONSIBILITIES INCLUDING GRIEVENCE PROCESS  
FINANCIAL DISCLOSURE  
ADVANCED DIRECTIVES INFORMATION

I hereby acknowledge that I have read and understand my Patient Rights and Responsibilities including the grievence process. I have also read and understand Metro Atlanta Endoscopy's Financial Disclosure and Advanced Directives information

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NAME Date/**Time**

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WITNESS Date/**Time**