PAVILION SPINE SURGERY CENTER

3193 Howell Mill Road Suite 315
Atlanta, GA 30327

_____ I acknowledge the receipt and opportunity to review the Patients' Rights and Responsibilities before the day of the procedure.

_____ I have been informed that Pavilion Spine Surgery Center does not perform high-risk pain management procedures. Therefore, The Center does not honor Advance Directives. In the event of an emergency, the patient will be stabilized and transferred to the hospital as soon as possible. The staff has a copy of Advance Directives if I should request one.

_____ I have been informed verbally and in writing that Dr. Kabakibou has ownership in the Pavilion Spine Surgery Center.

_____ _____

Signature Date