



NOTICE REGARDING ADVANCE DIRECTIVE POLICY

The center requires the following notice to be signed by each patient in order to be in compliance with the Patient Self Determination Act and State law.

An Advance Directive is a document or documentation allowing a person to give direction about future medical care or to designate another person to make medical decisions if the individual loses decision-making capability. Patients are not required to have an Advance Directive in order to receive treatment at the Center.

There are many types of Advance Directives, but the two most common forms are:

- **Living Wills** – instructions explaining wishes regarding health care should the individual be unable to make decisions.
- **Durable Power of Attorney** – A signed, dated, and witnessed document naming another person as an individual's agent or proxy to make medical decisions for that individual should they become unable to make decisions.

The type of Advance Directives that may apply to the Center are called "requests to forego resuscitative measures" or "do not resuscitate orders (collectively referred to as a DNR)". A DNR order is typically used by terminally ill patients who do not want to be resuscitated should they suffer a cardiac or respiratory arrest or other life-threatening situation.

The center is an outpatient facility, where only elective surgery and/or procedures are performed. If a patient should suffer a cardiac or respiratory arrest, or other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed Advance Directives. If you disagree, you must address this issue with your physician prior to signing this form.

Do you have a Living Will?

- ☐ Yes ☐ Did you bring a copy?
- ☐ No

By signing below, I acknowledge that I have consented to resuscitation and transfer to a higher level care. I have read and fully understand the information contained in this release form.

PATIENT or LEGALLY AUTHORIZED REPRESENTATIVE

DATE

RELATIONSHIP TO PATIENT IF NOT PATIENT

DATE

WITNESS

DATE