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NOTICE REGARDING ADVANCE DIRECTIVE POLICY

Each patient must sign this notice so the Office/Clinic/Healthcare Provider's Practice can comply with the Patient Self-Determination Act and applicable state law.

An Advance Directive is a document that allows a person to provide instructions about future medical care or designate another person to make medical decisions if the person loses decision-making capacity.
Patients do not need an Advance Directive to receive treatment at the Office/Clinic/Healthcare Provider's Practice.

There are several types of Advance Directives. The two most common are:

- **Living Wills** – written instructions about a person's health care wishes if the person cannot make decisions.

- **Durable Power of Attorney** – a signed, dated, and witnessed document naming another person as the individual's agent or proxy to make medical decisions if the individual cannot do so.

The Advance Directives most relevant to the Office/Clinic/Healthcare Provider's Practice are "requests to forego resuscitative measures" or "do not resuscitate" orders, collectively referred to as DNR orders. A DNR order is typically used by terminally ill patients who do not want resuscitation if they experience cardiac or respiratory arrest or another life-threatening situation.

The Office/Clinic/Healthcare Provider's Practice is a Medical Provider's Office/Clinic/Practice that provides elective medical, surgical and anesthesia related services and/or procedures. If a patient experiences cardiac or respiratory arrest or another life-threatening situation, the signed consent authorizes resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the practice is notifying you that it will not honor previously signed Advance Directives. If you disagree, you must discuss this issue with your physician before signing this form.

Do you have a Living Will?

☐ Yes ☐ Did you bring a copy, or can you provide our office/practice/clinic with one?

☐ No

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

Signature of patient or legally authorized representative (power of attorney) _____ Date _____

Printed Name _____ Time _____