



ACKNOWLEDGEMENT FOR ADVANCE DIRECTIVES

As your physician, we need to know if you have executed an Advance Medical Directive:

Yes _____ No _____

If yes, this Directive is in the form of:

- ____ Living Will
- ____ Durable Power of Attorney for Healthcare
- ____ Designation of a Healthcare Surrogate
- ____ A Do Not Resuscitate (DNR) Order

If you answered YES, could you please provide us with a copy of the forms at your earliest convenience and sign below.

If you answered NO, please read the following statement and sign below.

In the event you become unable to tell your physician and family how you want to be treated, federal and state laws provide ways for you to make your wishes known, the Federal Patient Self Determination Act states that each competent adult patient has the right to prepare a written "advance directive" regarding healthcare decisions. The advance directive is typically expressed in one or more of three basic types or forms; a Living Will declaration, a durable Power of Attorney for healthcare, or a Designation of Healthcare Surrogate, or representative to make healthcare decisions for you, the patient, when the patient becomes incapable of making those decisions. The Living Will enables you to indicate your wishes regarding, healthcare treatment and life-prolonging procedures and circumstances under which you wish these procedures to be withdrawn or withheld, and you may also designate a surrogate to carry out your wishes. Through a Durable Power of Attorney, you can name a person to communicate your wishes regarding medical, legal and financial matter should you become incapacitated to make decisions regarding medical treatment.

Advance directives can help protect your right to make medical choices that can affect your life. The stress on your family during a difficult time can be considerably reduced because your family will be relieved of the responsibility of trying to decide what your wishes would be. Your family and physician will have clear guidelines concerning your wishes for your care.

Signature/Date

Witness

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of Advanced Women's Health Specialists Notice of Privacy Practices.

Name

Signature/Date

If completed by a patient's personal representative, please print and sign your name in the space below.

Name/Relationship

Signature/Date

OFFICE USE ONLY: I have made a good faith effort to obtain a written acknowledgement of receipt Advanced Women's Health Specialists Notice of Privacy Practices but was unable to for the following reason:

____ Patient refused to sign ____ Patient unable to sign ____ Other _____
Employee Name/Date

