HEART & VASCULAR AMBULATORY SURGERY CENTER

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES and Acknowledgement of Patient Rights/Responsibilities, Disclosure of Ownership Interest and Acknowledgement of Notice of Privacy Practices

The Facility requires the following notice be signed by each patient prior to scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) and Florida laws and rules regarding advance directives. Advance directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury.

There are many types of advance directives, but the two most common forms are:

Living Wills

These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make his/her own decisions.

Durable Power of Attorney for Health Care

This is a signed, dated and witnessed paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.

In the ambulatory care setting, 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 for any patient. If you disagree, you must address this issue with your physician or anesthetist prior to signing this form.

[ ] I have read and fully understand the information in this release form
[ ] I DO NOT have a *Living Will* or *Durable Power of Attorney for Health Care*
[ ] I DO have a *Living Will* or *Durable Power of Attorney for Health Care* and a copy
[ ] has been provided to the facility
[ ] has NOT been provided to the facility
[ ] I have also been given a copy of Patient Rights and Responsibilities for this facility
[ ] I have also been given a copy of the Disclosure of Ownership Interest for this facility

[ ] I hereby acknowledge that I have received a copy of this practice's ***Notice of Privacy Practices***. I understand that if I have questions or complaints regarding my privacy rights that I may contact the appropriate person as outlined in the Complaint section of the ***Notice of Privacy Practices***. I further understand that the practice will offer me updates to this ***Notice of Privacy Practices*** should it be amended, modified, or changed in any way.

Itemized Bill – You have the right to an itemized bill for services which will be provided upon request.

I have read and fully understand the information presented in this release form.

Patient's Signature Date

Witness to Patient's Signature Date

If patient is unable to sign or is a minor, please sign below.

Relative or Legal Guardian Signature Date

Witness to Relative/Guardian Signature Date