Advance Directive Acknowledgment

Patient Name:_____

Social Security Number:_____ Birthdate:_____

Please read and initial the following four (4) statements:

1. I have been given written material about my right to accept or refuse medical treatments. Initials:_____

2. I have been informed that I am not required to formulate an Advanced Directive. Initials:_____

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this physician's office. Initials:_____

4. I understand that the terms of any Advanced Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. Initials:_____

<u>Please complete the following information, if applicable:</u>

- ☐ I have executed an Advanced Directive. It is on file at the offices of:

  _____

- ☐ I have not executed an Advance Directive.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____