Advance Directive Acknowledgement

Name: _____Social Security #: _____-_____-_____

Medical Records #: _____ Date: _____

Please read and initial the following four statements:

I have been given written materials about my right to accept medical treatment. _____

I have been informed that I am not required to formulate Advance Directives. _____

I understand that I am not required to formulate Advance Directives. _____

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

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

Please complete the following information, if applicable

( ) I have executed an Advance Directive. It is on file at the office of:

_____

( ) I have not executed an Advance Directive

_____ _____

Signed **Date**

_____ _____

Witness **Date**