Statement of Limitation Regarding Advance Directives

Note a revocation of advance directives or medical power of attorney

All patients have the right to participate in their own health care decisions and to make advance directives, or to execute power of attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Surgery Center respects and upholds those rights.

However, unlike an acute care hospital setting, the Surgery Center does not routinely perform high-risk procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to your risks, expected recover and care after your surgery.

Therefore, it is our policy, regardless of the contents of any advance directives or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directives or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree to this policy, we will be pleased to assist you in rescheduling the procedure.

Please check the appropriate box to answer the following question: ***Have you executed an advance directive, a living will, or a power of attorney that authorizes someone to make health care decisions for you?***

- ☐ ***YES.** I have an advance directive, living will or health care power of attorney and have furnished a copy to the Surgery Center of Gilbert.
- ☐ **YES**. I have an advance directive, living will or health care power of attorney but **HAVE NOT** furnished a copy to the Surgery Center of Gilbert.
- ☐ **NO.** I do not have an advance directive, living will or health care power of attorney.
- ☐ I would like to receive information on advance directives.

* If you checked the first YES box above, please provide us with a copy of that document to place in your medical record.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like to receive additional information, I acknowledge receipt of that information..

By: ____

Patient Signature

Patient Last Name:	Patient First Name:	Date:

If consent to the procedure is provided by anyone other than the patient, this form must be signed below by the person providing consent or authorization.

I acknowledge that I have read and understand the policy and contents, and agree to the policy as described.

By:____

Signature   Print Name

Relationship to Patient:

- ☐ Court Appointed Guardian
- ☐ Attorney in Fact
- ☐ Health Care Surrogate
- ☐ Other ____________________