ADVANCED REGIONAL Surgery Center, LLC

ADVANCE DIRECTIVE and PATIENT RESPONSIBILITY ACKNOWLEDGEMENT

I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). If I desire to exercise this right, I understand that I must inform my physician of my wishes. I understand that if I have a Living Will, Durable Power of Attorney, and/or Advance Directive, I must inform Advanced Regional Surgery Center. I am aware that in the event of a life-threatening emergency, it is the policy of Advanced Regional Surgery Center, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, to initiate resuscitative or other stabilizing measures. If an adverse event should occur during treatment at this facility I will be transferred to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, Advance Directive, or Health Care Power of Attorney. My agreement with this facility's policy will not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

☐ I decline to implement an Advance Directive

☐ I would like to implement an Advance Directive and I have given Advanced Regional Surgery Center a copy of such directive.

☐ I have been given the opportunity to receive a copy of the Privacy Notice (HIPAA)

☐ I have been informed of my Patients' Rights and Responsibilities and a copy has been made available to me.

I understand that I may revoke this consent ant any time by notifying Advanced Regional Surgery Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Advanced Regional Surgery Center took before receiving my revocation.

_____ _____

Signature of patient or patient's representative Date

_____

Printed Name of patient or patient's representative

_____ _____

Signature of witness Date

Pt label