Title: Advance Directive Acknowledgement Form
Policy Title: Advance Directives
Policy Number: PRG-2013-1000

1. You have the right to give written directions about future treatment **before** you become seriously ill or unable to make healthcare decisions. This is called an "Advance Directive".

2. You have the right to accept or refuse medical or surgical treatment.

3. An employee of the KTHFS Patient Registration Department will provide you with information to help you develop an Advance Directive regarding your healthcare. You are not required to make any Advance Directive about your future medical treatment. **This practice is completely voluntary.** It is entirely your choice.

4. You may consult your doctor, family, lawyer, or others before making a written Advance Directive.

5. If you decide to make an Advance Directive about future medical care it will become a part of your medical record at KTHFS. Photocopies of your fully executed and witnessed directive should be made for your personal records, your family members and your proxy and alternate if you have chosen them. The original or a copy should be furnished to your hospital of choice whenever you receive inpatient care.

6. You may revoke your Advance Directive at any time, in writing or simply by telling your attending physician or other healthcare provider or a witness, regardless of your physical or mental condition.

I understand my rights as set forth above. Please check one of the following statements:

☐ I have received information regarding my right to make an Advance Directive.

☐ I do not have an Advance Directive ☐ I would like receive more information.

☐ I do not have an Advance Directive and I do not want any information at this time.

☐ Yes, I do have an Advance Directive.

☐ Please find it attached ☐ Copy requested by KTHFS

Note: *It is the patient's responsibility to provide KTHFS with a copy of any Advance Directive document (living will, health care proxy, or medical power of attorney) or other document that could affect your care, if such document(s) exist.*

Patient Name: _____ E.H.R. No. _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Relationship to Patient: _____