ADVANCE DIRECTIVE ACKNOWLEDGEMENT

Patients Name: Last _____ First _____

** Middle Name (if applicable): _____

DOB: _____ Social Security Number: _____-_____-_____

Address: _____ City: _____

State: _____ Zip Code: _____

Please Read and Initial the Following:

1. I have signed a consent form regarding my right to accept or refuse medical treatment

   _____ Initials

2. I understand that I am not required to have an advanced directive to receive medical treatment at this health care facility

   _____ Initials

Please Check <u>One</u> of the Following Statements:

___ I have executed an Advanced Directive for healthcare

___ I have NOT executed an Advanced Directive for healthcare

Signature: _____ Date: _____

Office Staff: _____ Date: _____