



Execution of Advance Directive & Receipt of Advance Notices

- Advance Directives -

Are statements that indicate the type of medical treatment wanted or not wanted in the event you are unable to make those decisions, and who is authorized to make those decisions. The three most common forms of advance directive are:

- Living Wills
- Durable Power of Attorney
- POST – Physician Orders and Scope of Treatment

The physicians and staff at Pend Oreille Surgery Center value and respect our patients' rights to make informed decisions regarding their healthcare. Since surgical procedures performed at Pend Oreille Surgery Center are elective in nature, and expected to be of short duration; and since adverse incidents during surgery are not expected, your advance directive will be honored by Pend Oreille Surgery Center with the following State Law permitted limitation: **POSC will always attempt resuscitation and life-sustaining measures until such time the patient can be transferred to the nearest or best choice hospital.** A copy of your advance healthcare directive, if provided upon admission to our facility, will be included with your medical records in the event of an unexpected transfer.

I understand that I am not required to have an Advance Directive.

I understand that my advance directive will be honored during my admission to Pend Oreille Surgery Center and I have been informed of the State Law permitted limitation.

- I have executed an Advance Directive
- Copy provided Copy not provided

I have not executed an Advance Directive

By signing below, you, or your legal representative, acknowledge that this disclosure has been made prior to the start of your procedure, and that you have decided to have the procedure performed at Pend Oreille Surgery Center, LLC.

- Advance Notices -

The following was made available to me prior to the start of my procedure:

- Patient rights and responsibilities
- Privacy practices
- Advance directive information
- Financial and billing policy
- Information regarding physician financial interest and ownership.

Patient Name (print) _____

Patient Signature _____

Patient Representative/Guardian Signature _____ Date ____ / ____ / ____