ADOBE SURGERY CENTER, P.C.
2585 N. Wyatt Drive
Tucson, Arizona 85712
Phone: (520)721-2728 Fax: (520)721-0179

Welcome Letter

Hello,

We at Adobe Surgery Center would like to welcome you to our facility. Below you will find detailed information regarding your surgery and what to expect throughout the entire process. Please take a few minutes to read the information carefully; when you check in for your surgery, you will be asked to sign a document confirming that you have read and understand the information contained in this brochure.

Adobe Surgery Center is solely owned and operated by Sam Moussa, MD. We are pleased that you have chosen us to take part in your healthcare, and would like to inform you that it is your right to receive care elsewhere in the community should you choose to do so. Please note that all physicians associated with our practice are licensed to practice in the State of Arizona and are credentialed and privileged to perform procedures in our facility.

While receiving care at our facility, you should know that we have adopted nationally recognized Patient Rights and Responsibilities and have enclosed a copy for your review. Information regarding our Health Initiative Portability and Accountability Act policy is also enclosed for your review. Additionally, copies of both are posted in our waiting room. If you have any advance directives that you would like added to your chart please provide these at the time of your procedure.

We also have available for your review, a copy of our Advance Directives/DNR Policy, Grievance Policy, Fees for Services, and Payment Policy, which are all located in our Patient Information Binder, located in the waiting room. If you would like a copy of these documents please feel free to take one.

After your procedure, should you have any questions or concerns after business hours please dial 911 for all emergencies, or you may contact the on-call physician directly at (520) 600-8804. Please note, our physician will only return calls that are directly related to a post-op concern. All other inquiries will receive a call back the following business day. Our hours of operation are Monday through Friday from 8:00 am to 5:00 pm. We are closed Saturday and Sunday and most major holidays. If you have any concerns, complaints, or comments regarding the quality of care you receive while in our facility, please contact Sam Moussa, MD Administrator or the Director of Nursing, at (520) 721-2728.

Should you have a concern or complaint that has not been satisfied by our staff, you may contact the Arizona Department of Health at (602)364-2536, or Medicare beneficiaries may contact the Health Services Advisory Group at (800) 841-1602.

By signing below you are acknowledging that you have received the above information and that all of your questions regarding this information have been answered to your satisfaction.
Thank you again for allowing us to take part in your healthcare.
Regards,

Adobe Surgery Center Staff

I have received copies of the following

- ☐ ***Patients Rights and Responsibilities***
- ☐ ***HIPAA Notice of Privacy Practices***
- ☐ ***Advance Directives/Living Will, Healthcare Power of Attorney***
- ☐ ***Screening Colonoscopy vs. Diagnostic Colonoscopy***

Patient Name (please print)_____

Patient Signature_____Date_____

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PREPARING FOR YOUR PROCEDURE~

- You will need to bring a photo ID (i.e. driver's license, military ID), your insurance card, and any co-pay/deductibles with you.
- If there are any legal documents regarding Guardianship, Emancipation, or Power of Attorney, please bring them with you. We will require that a copy of all legal documents be in the patient's chart, prior to the start of Procedure. Please note that our facility does not honor Living Wills/ DNR orders, however, if you have one, we will place a copy of it in your record, and should a hospital transfer become necessary, a copy will be transferred with you.
- If you wear glasses, please bring them with you.
- If you use a rescue inhaler (i.e. Albuterol), please bring it on the day of Procedure. Many times the physician will have you use it just before Procedure.

EATING and DRINKING~

For all patients:

- **Please read the preparation sheet provided by our office for your particular procedure carefully**. **DO NOT** follow those provided by the pharmacy. Some instructions vary depending on the procedure being performed.
- Necessary medication can be taken with small amount of water early in the morning.
- *** Please be aware, if you do not follow the above listed criteria, due to health risks, your Procedure may be canceled or postponed.

FOLLOWING The Procedure

- **You MUST have a driver available to take you home**. If this person is not waiting for you in the lobby, we must have a VALID CONTACT PHONE number and they must be within 30 minutes of the Procedure center.
- There is absolutely no driving, operating heavy machinery, or making major/legal decisions for 24 hours following the Procedure due to the lingering effects of sedation.
- Following your Procedure, you may be discharged with written medication prescriptions that will require you to get them filled at the pharmacy.

WHAT TO EXPECT…

- Please sign in, take a seat, and wait for a staff member to assist you. The receptionist will go over paperwork with you, obtain accurate phone numbers for your ride home, and will collect your co-pay/deductible.
- Following check-in, a staff member will escort you back into the pre-procedure area.
- In the pre-op area, the a staff member will go over medical information, obtain vital signs, have you change into a gown and place an IV. Your physician will meet with you prior to your procedure to discuss the procedure and the sedation plan. When your procedure is over, you will be taken to the recovery area. Once you have met discharge criteria and are stable, awake, and oriented, post-op instructions (written and oral) will be reviewed prior to discharge.

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PRE-PROCEDURE MEDICATION INSTRUCTIONS

- To ensure your safety you must discuss any and all medications that you are taking with your physician. It is VITAL that we have all the details of your medical history and your current medication history.
- Our office will supply you with some information in addition to that contained in this brochure.
- If you are having any medical difficulties prior to your procedure, please let the physician's office know immediately of the issues.
- If you have any non-emergency medical problems the morning of the procedure, (ie. you wake up with a fever; flu-like symptoms; or your prep is not adequate, etc.), please call the Surgery Center at 520-721-2728 and let us know.
- If you have an emergency please call or have a family member call 911 and tell them you are having a medical emergency and what the nature of the emergency is. They will respond immediately to assess the problem and take care of you.

ASSOCIATED COSTS

If your physician deems it necessary to take biopsies or to remove polyps during your procedure these Specimens will be sent to a pathology lab. Your insurance information will be sent to the pathology lab. Please keep in mind that pathology is separate from your procedure and that you may receive a bill from pathology for costs that your insurance has not reimbursed.

If your physician decides it is necessary to perform an additional procedure (ie. adding an upper endoscopy to your colonoscopy procedure, ablation therapy to an upper endoscopy etc.) additional costs may be incurred.

Occasionally it is necessary for our physicians to order additional testing (ie. radiology services like barium enema, ultrasound, CAT Scans) following a procedure. These tests are separate from the procedure and may involve additional costs.

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Patients Rights and Responsibilities

Patient Rights:

- Adobe Surgery Center and medical staff have adopted the following statement of patient rights. This list shall include, but not be limited to, the patient's right to:
- Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.
- Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
- Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.
- Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Formulate advance directives regarding his or her healthcare, and to have ASC staff and practitioners who provide care in the hospital comply with these directives (to the extent provided by state laws and regulations).
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the ASC. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of the request).
- Reasonable responses to any reasonable request he/she may make for service.
- Leave the ASC even against the advice of his/her physician.
- Reasonable continuity of care.
- Be advised of the ASC grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge time is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the ASC contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.

- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the ASC.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- Know which ASC rules and policies apply to his/her conduct while a patient.
- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- **All personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.**

Patient Responsibilities:

- The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:
- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the ASC or physician when he/she is unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her hospital care are fulfilled as promptly as possible.
- The patient is responsible for following ASC policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and ASC personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the hospital.

All surgery center personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.

To report a complaint or grievance you may contact:
AzDHS – Licensing Services, 150 N. 18th Ave., 4th floor, Phoenix, Az, 85007
Or call (602)364-2536.
You may also contact the Medicare Beneficiary Ombudsman at
www.medicare.gov/ombudsman/resourses.asp

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or your protected health information may be provided to a physician to whom you have been referred or seek counsel from, to ensure that physician has the necessary information to diagnose or treat you.

Treatment and office visits in our facility will require that you be called by name in the reception area. You will be asked personal and medical history questions by medical personnel to ensure safe and appropriate care in our surgery center. You may share a pre- or post-op area with other patients in our surgery center.

Obtaining approval or scheduling procedures or a hospital stay may require that your relevant protected health information be disclosed to the health plan or medical facility.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, medical studies, and conducting or arranging for other business activities. You may be greeted by name at our reception desk and ask to complete registration forms or sign consent for procedures. We may also call you by name in the reception area when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or inform you of test results. We may contact you by telephone, E-mail, Postal Service or other forms of delivery services, as your doctor deems necessary.

Research: We may use and disclose medical information about our patients for research purposes, subject to the confidentiality provisions of state and federal law. Occasionally, researchers contact patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form. When approved through a special review process, other studies may be performed using your medical information without requiring your consent. These studies will not affect your treatment or welfare, and your medical information will continue to be protected. For example, a research study may involve a chart review to compare the outcomes of patients who received different types of treatment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity and National Security; Workers' Compensation; Inmates, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

See reverse side

Telephone calls to Adobe Gastroenterology/Surgery Center, P.C., may be monitored or recorded randomly, by management, for quality assurance or training purposes only.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or opportunity to object unless required by law.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Your Rights Regarding Your Health Information

You have the right to inspect and copy your protected health information. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must submit your request for medical records in writing to your Doctor.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request, in writing, must state the specific restriction requested and to whom you want the restriction to apply. *(Please ask the receptionist for a form.)*

Your physician is not required to agree to a restriction that you may request, unless you have requested a restriction on information disclosed to a health plan when you have covered the entire cost of service. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You also have the right to request, in writing, to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to ask your physician to amend your protected health information. If you believe your medical record is incorrect or incomplete, you may request to amend your records through the use of an authorized amendment form. The original form must be placed into your medical file at this practice. You may
Request an amendment form from this office. Your request must be made in writing and submitted to your doctor at Adobe Gastroenterology, 2585 N. Wyatt Drive, Tucson, AZ 85712. The original information will also be retained in your file.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided in this notice.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with us by notifying our HIPAA Compliance Officer. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before July 1, 2013.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. You may ask our office for a copy of this Notice at any time. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (520) 721-2728.

HEALTHCARE POWER OF ATTORNEY

Short Form

I,_____ , as principal, designate _____ as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective when I am unable to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when it is unclear whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint

_____ as my agent.

I have __I have not __completed and attached a living will to provide specific direction to my agent. My agent is directed to follow those choices I have initialed in the living will.

I have __ I have not __completed a prehospital medical directive pursuant to Section 36-3251, Arizona Revised Statutes.

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

_____ _____

Signature (or mark) of Principal Address of Agent

Date: _____ Telephone
Of Agent: _____

Time: _____

Verification

I affirm that: (1)I was present when this health care power of attorney was dated and signed or marked or (2) the person making this power of attorney directly indicated to me that the power of attorney expressed that person's wishes and that the person intended to adopt this power of attorney at that time.

I certify that: I have not been designated to make medical decisions for the person who signs this health care power of attorney; I am not directly involved with providing health care to that person; I am not related to that person by blood, marriage or adoption; and I am not entitled to any part of that person's estate.

_____ _____

Date:_____ Date: _____

(NOTE: *This document may be notarized instead of being witnessed.)* Arizona Hospital Association

PODER DE CUIDADO DE SALUD

Formlulario Corto

Yo, _____,como principal, designo a mi agente para todos los asuntos relacionados con mi cuidado de salud, incluso, sin restricciones, el poder completo de dar o rehusar el consentimiento para el cuidado medico, quirúrgico y de hospital y otro cuidado de salud relacionado. Este poder entra en vigor con mi incapacidad de hacer o comunicar las decisiones de cuidado de salud. Todas las acciones de mi agente bajo este poder, durante cualquier periodo cuando no puedo hacer ni comunicar las decisiones de cuidado de salud 0 cuando hay duda si estoy muerto 0 vivo, tienen el mismo efecto en mis herederos, beneficiarios y representantes personales como si estuviera vivo, competente y representado por *mi* mismo.

Si mi agente no esta dispuesto a servir o continuar a servir, o no puede hacerlo, por la presente nombro _____como mi agente.

He__ No he __ completado y adjuntado un testamento en vivo para el propósito de proporcionar instrucciones especificas a mi agente. Se manda a mi agente que ejecute las selecciones que he firmado con mis iniciales en el testamento en vivo.

He__ No he__ completado una directiva medica antes de entrar al hospital de acuerdo con la Sección 36-3251 de los Estatutos Revisados de Arizona.

Se hace esta directiva de cuidado de salud bajo la Sección 36-3221, Estatutos Revisados de Arizona, y se continua en vigor para todos que pueden confiar en esa, excepto a quienes he avisado de su revocación.

_____ _____

Firma (o cruz) de Principal Dirección de Agente

Fecha:_____ Numero de Teléfono de Agente_____

Hora:_____

Verificacion

Afirmo que: (1) Estuve presente cuando este poder de cuidado de salud fue fechado y firmado o firmado con una cruz o (2) las persona que hizo este poder me indico directamente que el poder expreso los deseos de la dicha persona y que la persona se propuso adoptar este poder por entonces.

Certifico que: No se me ha designado para hacer las decisiones medicas para la persona que firma este poder de cuidado de salud; no participo directamente en el proporcionar de cuidado de salud a la persona; no tengo parentesco con esa persona por sangre, matrimonio o adopción; y no tengo derecho a ninguna parte de los bienes de la persona.

_____ _____

Fecha: _____ Fecha: _____

LIVING WILL

Statutory Short Form

(Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should ***initial*** *that statement.* ***Read all of these statements carefully before you initial your selection.*** *You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs* 1, 2, 3, *and 4, but if you initial paragraph* 5 *the others should* ***not*** *be initialed.)*

1. __ If I have a terminal condition I **do not** want my life to be prolonged and I **do not** want life sustaining treatment, beyond comfort care, that would serve **only** to artificially delay the moment of my death.

2. __ If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I **do** want the medical treatment necessary to provide care that would keep me comfortable, but I **do not** want the following:
   __ (a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing.
   __ (b) Artificially administered food and fluids.
   __ (c) To be taken to a hospital if at all avoidable.

3. __ Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

4. __ Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

5. __I want my life to be prolonged to the greatest extent possible.

6. __This living will is effective only while I am unable to make or communicate my decisions.

Other or Additional Statements of Desires

I have____ I have not____ attached additional directions or limitations.

Dated:_____Signature or Mark of Person Making Living Will _____

Verification

I affirm that: (1) I was present when this living will was dated and signed or marked or (2) that the person making this living will directly indicated to me that the living will expressed that person's wishes and that the person intended to adopt it at that time.

I certify that: I have not been designated to make medical decisions for the person who signed this living will, I am not directly involved with providing health care to that person, I am not related to that person by blood, marriage, or adoption and I am not entitled to any part of that person's estate.

_____ _____

Date:_____ Date:_____

(Note: *This document may be notarized instead of being witnessed.)*

TESTAMENTO EN VIVO

.....

Formulario Corto Estatutario

(Abajo se resumen algunas declaraciones generales acerca de sus opciones de cuidado de salud. Si Ud. esta de acuerdo con una de las declaraciones, debe firmar esa declaración con sus iniciales. ***Lea todas las declaraciones cuidadosamente antes de firmar su selección con sus iniciales.*** *También, puede escribir su propia declaración sobre el tratamiento que sustenta la vida y otros asuntos relacionados con su cuidado de salud. Puede firmar con sus iniciales cualquier combinaci6n de los parrafos 1, 2, 3 y 4, pero si Ud. firma con iniciales el parrafo 5, no firme los otros.)*

1.____ Si tengo una condición fatal, **no** quiero que se prolongue mi vida y **no** quiero el tratamiento que sustenta la vida, fuera del cuidado de alivio, que **solamente** serviría para demorar artificialmente el momento de mi muerte.

2.____ Si estoy en una condición fatal o un coma irreversible o incurable, **si** quiero el tratamiento medico necesario para proporcionar el cuidado que me mantiene el alivio, pero **no** quiero lo siguiente:

____(a) La resucitación cardiopulmonar, por ejemplo: el uso de drogas, choque eléctrico y respiración artificial.

____(b) El alimento y fluidos dados artificialmente.

____(c) Que se me lleve al hospital si es posible evitarlo.

3.____ No obstante mis otras direcciones, si se tiene conocimiento de que estoy embarazada, no quiero que se niegue ni quite el tratamiento que sustenta la vida si es posible que el embrión/feto se desarrollara al punta de nacimiento vivo con el uso continuo del tratamiento que sustenta la vida.

4.____ No obstante mis otras direcciones, si quiero el uso de todo el cuidado medico necesario para tratar mi condición hasta que mis médicos concluyen razonablemente que mi condición es fatal o irreversible e incurable o estoy en un estado vegetativo persistente.

5.____ Quiero que se prolongue mi vida a la mayor extensión posible.

6.____ Este testamento en vivo esta vigente solamente mientras que no puedo hacer ni comunicar mis decisiones.

Otras Declaraciones O Declaracions Adicionales de Deseos

He___ No he____ adjuntado direcciones adicionales 0 limitacions.

Fecha:_____ Firma o Cruz de la persona
que hace el testamento en vivo _____

Verificacion

Afirmo que: (1) Estuve presente cuando este poder de cuidado de salud fue fechado y firmado o firmado con una cruz o (2) la persona que hizo este poder me indico directamente que el poder expreso los deseos de la dicha persona y que la persona se propuso adoptar este poder por entonces.

Certifico que: No se me ha designado para hacer las decisiones medicas para la persona que firma este poder de cuidado de salud; no participo directamente en el proporcionar de cuidado de salud a la persona; no tengo parentesco con esa persona por sangre, matrimonio o adopción; y no tengo derecho a ninguna parte de los bienes de la persona.

_____ _____

Fecha: _____ Fecha: _____

(NOTE: Se puede certificar este documento por notorio en lugar de tener testigos