Legacy Surgery Center

6918 Gunn Highway, Suite E. • Tampa, Florida 33625 • Phone 813-852-2500 • Fax 813-852-2541

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES and Acknowledgement of Patient Rights/Responsibilities, Acknowledgement of Disclosure of Ownership Interest and Acknowledgement of Notice of Privacy Practice

The Facility requires the following notice be signed by each patient prior to scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) and Florida laws and rules regarding advance directives. Advance directives are statements that indicates the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are made and witnessed prior to serious illness or injury.
There are many types of advance directives, but the two most common forms are:

Living Wills

These generally state the type of medical care an individual wants or does not want if he/she becomes unable to make medical decisions.

Durable Power of Attorney for Health Care

This is a signed, dated and witnessed paper naming another person as an individual's agent or proxy to make medical decisions for that individual if he/she should become unable to make his/her own decisions.

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed advance directives for any patient, if you disagree, you must address this issue with your physician or anesthetist prior to signing this form.

[ ] I have read and fully understand the information in this release form
- **[ ] I DO NOT have a *Living Will* or *Durable Power of Attorney for Health Care***
- **[ ] I DO have a *Living Will* or *Durable Power of Attorney for Health Care* and a copy**
  - **[ ] has been provided to the facility**
  - **[ ] has NOT been provided to the facility**

[ ] I have also been given a copy of the Patient Rights and Responsibility for this facility

[ ] I have also been given a copy of the Disclosure of Ownership Interest for this facility

[ ] I hereby acknowledge that I have received a copy of this practice's ***Notice of Privacy Practice***. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the appropriate person as outlined in the complaint section of the ***Notice of Privacy Practice***. I further understand that the practice will offer me updates to this ***Notice of Privacy Practice*** should it be amended, modifies or change in any way.

I have read and fully understand the information presented in this release form.

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Patient's Signature	Date	Witness to Patient's Signature	Date

If patient is unable to sign or is a minor, please sign below.

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Relative or Legal Guardian Signature	Date	Witness to Relative/Guardian Signature	Date