Via Care
— your health, your way —

PATIENT INFORMATION

Who referred you:_____

NAME: _____ DATE OF BIRTH:_____/_____/_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHARMACY NAME: _____ ADDRESS: _____ PHONE:_____

HOME PHONE NUMBER: (_____) _____-_____ ☐ PREFERRED METHOD OF CONTACT

WORK PHONE NUMBER: (_____) _____-_____ ☐ PREFERRED METHOD OF CONTACT

CELL PHONE NUMBER: (_____) _____-_____ ☐ PREFERRED METHOD OF CONTACT

E-MAIL: _____@_____ ☐ PREFERRED METHOD OF CONTACT

GENDER: ☐ F ☐ M SOCIAL SECURITY NUMBER (SSN): _____ - _____ - _____ ☐ DO NOT HAVE A SSN

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Living Together ☐ Prefer not answer

ETHNICITY: ☐ Hispanic or Latino (all races) ☐ Not Hispanic or Latino (all races)

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasian/White
☐ Native Hawaiian or other Pacific Islander ☐ Prefer not to answer Other: _____

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other _____

EMERGENCY CONTACT PERSON: _____

PHONE NUMBER: (_____) _____-_____ RELATIONSHIP TO PATIENT: _____

IS PATIENT A MINOR? ☐ Yes ☐ No (skip to Insurance / Income Information)

NAME OF PERSON RESPONSIBLE IF PATIENT IS A MINOR: _____

PHONE NUMBER: (_____) _____-_____ RELATIONSHIP TO PATIENT: _____

INSURANCE / INCOME INFORMATION

DO YOU HAVE HEALTH INSURANCE? ☐ Yes (complete information below) ☐ No (skip to Income and Family Size)

NAME OF INSURANCE PROVIDER: _____

POLICY NUMBER: _____ BIC ISSUE DATE (MEDI-CAL ONLY): _____

DID YOU BRING YOUR INSURANCE CARD? ☐ Yes ☐ No DID YOU BRING PROOF OF RESIDENCY? ☐ Yes ☐ No

MONTHLY INCOME (BEFORE TAXES): $_____ FAMILY SIZE (INCLUDE YOURSELF): _____

DID YOU BRING PROOF OF INCOME? ☐ Yes ☐ No

REASON FOR VISIT

☐ HIV/STD Check ☐ Annual Physical Exam ☐ Birth Control ☐ Pregnancy Test ☐ Pap Smear ☐ Family Planning
☐ Diabetes ☐ High Blood Pressure ☐ Cholesterol ☐ Dental Annual Exam ☐ Dental Cleaning ☐ Drug or Alcohol Abuse
☐ Other: _____

highlighted data is required

HEALTH HISTORY

PATIENT NAME: | DATE OF BIRTH:

ADDRESS:

IMPORTANT: The purpose of these questions is to assist your doctor in evaluating your seual and reproductive health in addition to the issue or concern you have today. This evaluation is also an opportunity to provide you with information to maintain your health, without making any judgments with respect to your lifestyle. It is our goal to keep all information confidential within the law, and to respect your privacy. You are encouraged to ask questions. If you have any concerns about the information that you share, please let your doctor know.

PAST MEDICAL HISTORY: List any medical problems that you have been told you have

1.		3.	
2.		4.	

PAST SURGICAL / HOSPITALIZATION HISTORY: List any surgeries or hospitalizations you have had

1.		3.	
2.		4.	

FAMILY MEDICAL HISTORY: List medical problems your family members have & how they are related to you

1.		3.	
2.		4.	

PAST SOCIAL HISTORY: check box next to any that apply and fill in the blanks

SMOKING: _____ Cigarettes/ Packs per day ALCOHOL: _____ Drinks: per day/week

DRUG USE: ☐ Marijuana ☐ Meth ☐ Cocaine ☐ Heroine ☐ Other: How Often: _____

IMMUNIZATIONS STATUS:

☐ Rubella/MMR ☐ Hep B ☐ Pneumonia ☐ T.B. skin test ☐ Hep A ☐ Tetanus ☐ Influenza

Any history of blood transfusion or exposure to blood products? ☐ Yes ☐ No

Any history of family violence or abuse? ☐ Yes ☐ No Please comment:

Tuberculosis Positive: ☐ Yes ☐ No

REVIEW OF MEDICAL SYSTEMS/PROBLEMS: check off any problems you currently have

General
- ☐ Fever
- ☐ Weight Loss/gain
- ☐ Rheumatic Fever

HEENT
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Runny Nose
- ☐ Mouth Sores

Respiratory
- ☐ Problem breathing
- ☐ Cough
- ☐ Asthma

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Increased thirst

Hematological
- ☐ Easy bruising
- ☐ Bleeding
- ☐ Cancer history
- ☐ Anemia

Neurology
- ☐ Seizure History
- ☐ Stroke
- ☐ Headache

Cardiovascular
- ☐ Chest Pain
- ☐ Artificial Valve
- ☐ Mitral Valve Prolapse
- ☐ Palpitations
- ☐ Dizziness
- ☐ High Blood Pressure
- ☐ High Cholesterol

Gastrointestinal
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Rectal bleeding
- ☐ Liver problems

Urinary
- ☐ Urine infection
- ☐ Urine burning
- ☐ Difficulty Urinating

Muscular/Skeletal
- ☐ Arthritis
- ☐ Osteoporosis

Dermatology
- ☐ Rashes
- ☐ Skin cancers

Kidney Problems
- ☐ Kidney Problems
- ☐ Liver Problems

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep problems

Do you need antibiotics before dental treatment? ☐ Yes ☐ No

Have you ever had a problem with dental treatment? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No

ADDITIONAL PATIENT INFORMATION

Name: Date of Birth:

Address: City: State: Zip:

Please select all that apply

General Status

☐ Veteran	☐ Seasonal
☐ Migrant	☐ Homeless
☐ Limited English Proficiency	☐ Public Housing

Sexual Orientation

☐ Lesbian, gay or homosexual	☐ Straight or heterosexual
☐ Bisexual	☐ Do not know
☐ Choose not to disclose	☐

Gender Identity

- ☐ Male
- ☐ Female
- ☐ Female-to-Male (FTM) / Transgender Male/Trans Man
- ☐ Male-to-Female (MTF) / Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively male or female
- ☐ Choose not to disclose
- ☐ Additional gender category or other, please specify

NAME:_____ Date of Birth:_____/_____/_____

Office Use Only:	☐ A	☐ B	☐ C	☐ D	☐ E	☐ F	☐ G
Pay Schedule	**No pay**	**50%**	**60%**	**70%**	**80%**	**90%**	**Full Pay**

Consent for Treatment

I, the undersigned, hereby consent to the administration and performance of all diagnostic procedures and treatment, which, in judgment of my physician/dentist, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my attending physician/dentist, neither said physician/dentist, nor Via Care Community Health Center shall be liable for the consequences of such decision.

REQUEST FOR PROVISION OF MEDICAL/DENTAL SERVICES

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I may request information about the test(s), treatment(s), procedure(s), contraceptive method(s), to be provided including benefits, risks, possible problems/complications and alternative choices. I understand that I should ask questions about anything I don't understand. I understand that a physician/dentist is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical/dental services at Via Care Community Health Center.

I understand that if tests for certain sexually transmitted infections are positive; reporting of positive results to public health agencies is required by law.

I understand that if further diagnosis or treatment is needed for any medical/dental concerns, I will be given a referral(s) if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that the confidentiality will be maintained as much as is possible. I give permission for any and all information to be released to my insurance company if they request it for payment of services.

I hereby request that a person authorized by Via Care Community Health Center provide appropriate evaluation, testing, and treatment (including birth control drug) or device, if I request it.

Acknowledgement of Receipt of Notice of Privacy Practices / HIPAA

Use and disclosure of protected health information is regulated by a federal law known as the health insurance probability and Accountability Act of 1996("HIPAA"). HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information. The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of Via Care Community Health Center Notice of Privacy Policies on the date indicated below.

Acknowledgement of Voluntary Participation

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she solely participates in the Title X program on a voluntary basis. Patient will not be subjected to coercion to receive services or to use any particular method of family planning. Acceptance of family planning services will not be a prerequisite to eligibility for any other services or assistance from or participation in any other programs.

Patient Signature: _____ ***Print Name:*** _____ ***DATE:*** _____

Signature of Witness: _____ ***Print Name:*** _____ ***Date:*** _____

HIE Authorization Form

By signing this form, I give consent to VIA Care to bi-directionally share my information electronically with other health care providers, hospitals, and Health Information Exchanges (HIE).

☐ I Opt Out: VIA Care may not share any of my health information through HIE

Print Name: _____

Signature: _____ Date: _____

NO-SHOW/CANCELLATION ACKNOWLEDGEMENT

Via Care has a No-Show/Cancellation Policy that is currently in effect. This acknowledgement is to ensure that all of our patients are aware of the policy and how it may impact their care.

The importance of keeping a scheduled appointment is to ensure that our patients are cared for in a timely manner as well as to see that care is consistently provided to each and every Via Care patient.

Individuals Responsibility

- If you No-Show or fail to cancel an appointment at least 24 hours before your scheduled appointment time staff will remind you of the importance of keeping appointments.

- If this occurs two (2) or more times in a six-month (6) period, you may ***NOT*** make future appointments, and all scheduled appointments may be cancelled, and you may only be seen on a walk-in basis, *if there is availability that day.*

I understand that Via Care has a NO SHOW/CANCELLATION policy. Your health is important to us. We look forward to providing you with quality and accessible care.

_____ Date _____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Payment Policy

1. As a patient of Via Care Community Health Center (VCCHC), I understand and agree that:
   - If I find it necessary to cancel a scheduled appointment, I will notify VCCHC at least 24 hours in advance.
   - If I am a no show for my appointment; I lose eligibility for dental services.
2. If I am 15 minutes late to my appointment:
   - I may or may not be seen, depending on the office schedule.
   - If I am more than 15 minutes late, I will be classified as a "No Show."
3. Payment is required at the time of each appointment.

Consent for Treatment

I give my consent to the use of all services deemed necessary to complete the required treatment including, but not limited to, the administration of anesthesia, radiology and any needed medications. I also understand that no warranty or guarantees can be made as to the results of treatment. I hereby agree to release this clinic and its employees from further responsibility with regard to permission for treatment.

Consent for Services

The dental procedure to be performed has been explained to me, and I understand what is to be done. This is my consent to the treatment plan indicated, and to any other treatment deemed necessary or advisable depending on the judgment of the attending doctor.

I have been informed and understand that occasionally there are complications of the surgery, drugs and anesthesia. The more common complications are pain, infection, swelling, bleeding, bruising and discoloration, temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek or teeth. It has been explained to me that pain, numbness and occasionally inflammation of the skin (thrombophlebitis) may occur from an injection. Less common complications include the possibility of the adjacent teeth, restorations in other teeth, or injury to other tissues, referred pain to the ear, neck, head, nausea, vomiting, allergic reactions bone fractures, and delayed healing. Sinus complications, which may include a nasal antral fistula or opening into the sinus from the mouth, may occur with removal of upper teeth.

Medications, drugs, general anesthetics, and prescriptions may cause drowsiness, lack of awareness and coordination, which could be increased by the use of alcohol or other drugs. Thus I have been advised not to operate any vehicles or hazardous devices for at least 24 hours or until I have fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care.

I acknowledge the receipt of an understand the post-operative instructions. It has been explained to me, and I understand that there is no warranty or guarantee as to any result and/or cure. I understand that I can ask for a full recital of any and all possible risks attendant to my care by just asking.

Patient's Signature: _____ Date:_____

Witness:_____ Date:_____

Dentist:_____ Date:_____

Pharmacy Release Information

Via Care accepts the majority of insurances.
My Health LA Patients will automatically receive their medications in Via Care's Pharmacy.

☐ Option 1:

Pharmacy Name : Via Care Pharmacy		
Pharmacy Address: 615 S. Atlantic Blvd.		
City: Los Angeles	State: California	Zip Code: 90022
Phone: (323) 268-9191		

☐ Option 2:

Pharmacy Name :		
Address:		
City:	State: California	Zip Code:
Phone:		

☐ Option 3

Pharmacy Name:		
Address:		
City:	State:	Zip Code:
Phone:		

By signing this form, I give permission to Via Care Community Health Center to retrieve and review my outside medication history from the pharmacy listed above. I also certify that this is my current pharmacy of choice.

Patient Name (Print):_____

Signature: _____ Date: _____

Patient Name: _____ Chart ID#_____

D.O.B. _____

Would you like to receive a text or voice message reminder of your appointment?

Please check one:

- ❑ Opt out no
- ❑ Text message
- ❑ Voice message
    - o Please circle preferred time:

        Morning Afternoon Evening

Please verify cell phone number_____

Language preference (please check one)

- ❑ English
- ❑ Spanish

Would you like access to our patient portal access?

- ❑ Opt out no
- ❑ Yes (please provide email) _____

Signature / _____Date: _____

Staff Signature_____

TELEMEDICINE

Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Via Care Community Health Center at (323) 268-9191.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of California and will be in California during my telemedicine visit(s).

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
_____	_____
Witness Signature	Date

PATIENT CONFIRMATION OF RECEIPT OF
"ADVANCE DIRECTIVE"

I, _____, confirm that I have been given a copy of my "California Advance Health Care Directive."

My Advance Directive lets me decide how I want to be treated if I get very sick at some time in the future. I can talk with my family, friends, and doctor about my wishes.

Why is this important?

1. Other people may not understand what you are going through with your health
2. It will help you think about what you want.
3. It can save you money. Treatments you may not need can be avoided.
4. It can bring you closer to your family and your caretakers like your doctor.

Take the form home to read and think about how you want to fill it out. Bring this form back to share with your doctor.

Signature: _____ Date: _____

View "**https://prepareforyourcare.org/welcome**" to learn more about this form.

Patient – Physician/Dentist Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical/dental malpractice, that is as to whether any medical/dental services redered under this contract were unnecessary of unauthorized or were improperly, negligently or incompletently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: it is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below indentified physician/dentist, medical/dental group or association, their partners , associates, corporations, partnership, employees, agents, clinics and/or providers (hereinafter collectively referred to as physicians) to a patient, including any spouse or heirs of the patient and any childtren, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician/Dentist of any action in any court by physician/dentist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However , following the assertion of any claim against Physician/Dentist , any said dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail postage prepaid, to all parties, describing the claim against (physicians, the amount of damage sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The patient shall thereafter select a neutral arbitrator who was previously a California Superior Court Judge, to preside over the matter; both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil procedure."1280-1295 and the federal arbitration Act (9U.S." 1-4)". The parties shall bear their own cost, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician/Dentist not only after the date it is signed (including, but not limited to, emergency treatment) but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician/Dentist within 30 days of signature and if not revocable will govern all medical/dental services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with California law.
I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OR MEDICAL/DENTAL MALPRACATICE DECIDED BY A NEUTRAL ARBITRATOR AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ Patient's Signature	_____ Date	_____ Print Patient's Name
_____ Physician's/Dentist's or Duly Authorized Representative Signature	_____ Date	_____ Print or Stamp Name Physician's/Dentist's Medical/Dental Group or Association
_____ Signature of Translator (if applicable)	_____ Date	_____ Print Name of Translator
_____ Patient Representative (if applicable)	_____ Date	_____ Print Name and Relationship to Patient

Signed copy of this document is to be given to the patient. The Original is to be filed in patient's medical/dental record.

California Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 **Choose a medical decision maker, Page 3**

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

They are also called a health care agent, proxy, or surrogate.

Part 2 **Make your own health care choices, Page 6**

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 **Sign the form, Page 11**

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 12, or a notary on Page 13.

Your Name

Developed by PREPARE™ for your care

Revised 08/20/2020

This is a legal form that lets you have a voice in your health care.

It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

What should I do with this form?

- Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

What if I have questions about the form?

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your doctors, nurses, social workers, family, or friends to help.
- Lawyers can help too. This form does not give legal advice.

What if I want to make health care choices that are not on this form?

- On Page 10, you can write down anything else that is important to you.

When should I fill out this form again?

- If you change your mind about your health care choices
- If your health changes
- If your medical decision maker changes

If you and your spouse divorce, that person will no longer be your decision maker.

Give the new form to your medical decision maker and medical providers.

Destroy old forms.

Share this form and your choices with your family, friends, and medical providers.

Revised 08/20/2020

Part 1 Choose your medical decision maker

Your medical decision maker can make health care decisions for you if you are not able to make them yourself.

A good medical decision maker is a family member or friend who:

- is 18 years of age or older
- can talk to you about your wishes
- can be there for you when you need them
- you trust to follow your wishes and do what is best for you
- you trust to know your medical information
- is not afraid to ask doctors questions and speak up about your wishes

Your decision maker cannot be your doctor or someone who works at your hospital or clinic, unless they are a family member.

What will happen if I do not choose a medical decision maker?

If you are not able to make your own decisions, your doctors will turn to family and friends or a judge to make decisions for you. This person may not know what you want.

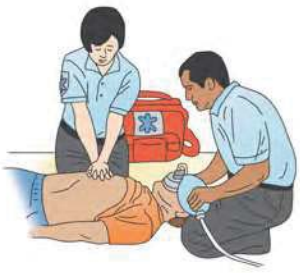
If you are not able, your medical decision maker can choose these things for you:

- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- who can look at your medical information
- what happens to your body and organs after you die

Revised 08/20/2020

Here are more decisions your medical decision maker can make:

Start or stop life support or medical treatments, such as:

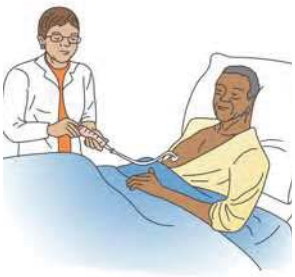


- **CPR or cardiopulmonary resuscitation**
  cardio = heart • pulmonary = lungs • resuscitation = try to bring back

  This may involve:
  - pressing hard on your chest to try to keep your blood pumping
  - electrical shocks to try to jump start your heart
  - medicines in your veins

- **Breathing machine or ventilator**
  The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.

- **Dialysis**
  A machine that tries to clean your blood if your kidneys stop working.

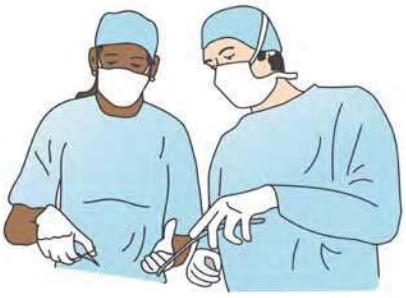


- **Feeding Tube**
  A tube used to try to feed you if you cannot swallow. The tube can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.

- **Blood and water transfusions (IV)**
  To put blood and water into your body.

- **Surgery**

- **Medicines**



End of life decisions your medical decision maker can make:

- call in a religious or spiritual leader
- decide if you die at home or in the hospital
- decide about autopsy or organ donation
- decide about burial or cremation

Your Name

By signing this form, you allow your medical decision maker to:

- agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself
- decide what happens to your body after you die, such as funeral plans and organ donation

If there are decisions you do not want them to make, write them here:

When can my medical decision maker make decisions for me?

- ☐ ONLY after I am not able to make my own decisions
- ◯ NOW, right after I sign this form

Write the name of your medical decision maker.

I want this person to make my medical decisions if I am not able to make my own:

first name | last name

phone #1 | phone #2 | relationship

address | city | state | zip code

If the first person cannot do it, then I want this person to make my medical decisions:

first name | last name

phone #1 | phone #2 | relationship

address | city | state | zip code

To make your own health care choices, go to Part 2 on Page 6. If you are done, you must sign this form on Page 11.

Your Name

Part 2 Make your own health care choices

What Matters Most in Life: Quality of life differs for each person.

For some people, the main goal is to be kept alive as long as possible even if:

- They have to be kept alive on machines and are suffering
- They are too sick to talk to their family and friends

For other people, the main goal is to focus on quality of life and being comfortable.

- These people would prefer a natural death, and not be kept alive on machines

Other people are somewhere in between. **What is important to you?**

Your goals may differ today in your current health than at the end of life.

TODAY, IN YOUR CURRENT HEALTH

Put an X along this line to show how you feel today, in your current health.

My main goal is to live as long as possible, no matter what.

Equally Important

My main goal is to focus on quality of life and being comfortable.

AT THE END OF LIFE

Put an X along this line to show how you would feel if you were so sick <u>that you may die soon</u>.

My main goal is to live as long as possible, no matter what.

Equally Important

My main goal is to focus on quality of life and being comfortable.

If you want to write down why you feel this way, go to Page 10.

Your Name

What Matters Most in Life: Quality of life differs for each person. What is important to you?

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

At the end of life, which of these things would be very hard on your quality of life?

Check the things below that would make you want to focus on comfort rather than trying to live as long as possible.

- ☐ Being in a coma and not able to wake up or talk to my family and friends
- ☐ Not being able to live without being hooked up to machines
- ☐ Not being able to think for myself, such as dementia
- ☐ Not being able to feed, bathe, or take care of myself
- ☐ Not being able to live on my own
- ☐ Having constant, severe pain or discomfort
- ☐ Something else _____

☐ **OR**, I am willing to live through all of these things for a chance of living longer.

Is religion or spirituality important to you? ☐ Yes ☐ No

If you have one, what is your religion? _____

What should your medical providers and medical decision maker know about your religious or spiritual beliefs?

_____

_____

If you are dying, where do you want to be?

☐ at home ☐ in the hospital ☐ either

_____
Your Name

If you want to write down more about why you feel this way, go to Page 10.

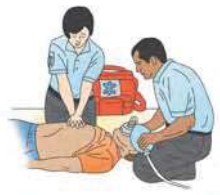
How Do You Balance Quality of Life with Medical Care?

Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

Please read this whole page before making a choice.

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.



Check the one choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

- ☐ **Try all life support treatments** that my doctors think might help. I want to **stay on life support** treatments even if there is little hope of getting better or living a life I value.
- ◯ Do a **trial of life support treatments** that my doctors think might help. But, I **DO NOT want to stay on life support** treatments if the treatments do not work and there is little hope of getting better or living a life I value.
- ◯ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a **natural death**.

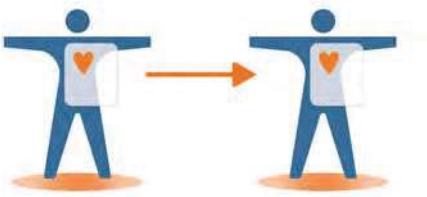
What else should your medical providers and decision maker know about this choice? Or, why did you choose this option?

If you want to write down more about why you feel this way, go to Page 10.

Your decision maker may be asked about organ donation and autopsy after you die. Please tell us your wishes.

ORGAN DONATION

Some people decide to donate their organs or body parts. What do you prefer?



☐ I **want** to donate my organs or body parts.

Which organ or body part do you want to donate?

☐ Any organ or body part

☐ Only _____

☐ I **do not** want to donate my organs or body parts.

What else should your medical providers and medical decision maker know about donating your organs or body parts?

_____

_____

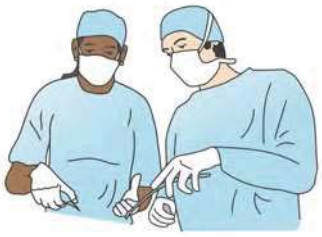
AUTOPSY

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

☐ I **want** an autopsy.

☐ I **do not** want an autopsy.

☐ I **only** want an autopsy if there are questions about my death.



FUNERAL OR BURIAL WISHES

What should your medical providers and decision maker know about how you want your body to be treated after you die, and your funeral or burial wishes?

_____

_____

If you want to write down more about why you feel this way, go to Page 10.

What else should your medical providers and medical decision maker know about you and your choices for medical care?

If you named a medical decision maker on this form: How strictly do you want them to follow your wishes if you are not able to speak for yourself?

Flexibility allows your decision maker to change your prior decisions if doctors think something else is better for you at that time.

Put an X next to the one sentence you most agree with.

- ☐ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ◯ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these wishes I NEVER want changed:

- ◯ **No Flexibility:** I want my decision maker to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

Part 3 Sign the form

Before this form can be used, you must:

- sign this form if you are 18 years of age or older
- have two witnesses sign the form or a notary

Sign your name and write the date.

sign your name _____ today's date _____

print your first name _____ print your last name _____ date of birth _____

address _____ city _____ state _____ zip code _____

Witnesses or Notary

Before this form can be used, you must have 2 witnesses sign the form or a notary. The job of a notary is to make sure it is you signing the form.

Your witnesses must:

- be 18 years of age or older
- know you
- agree that it was you that signed this form

Your witnesses cannot:

- be your medical decision maker
- be your health care provider
- work for your health care provider
- work at the place that you live (if you live in a nursing home go to Page 13)

Also, one witness cannot:

- be related to you in any way
- benefit financially (get any money or property) after you die

Witnesses need to sign their names on Page 12.
If you do not have witnesses, a notary must sign on Page 13.

Have your witnesses sign their names and write the date.

By signing, I promise that _____ signed this form.
(the person named on Page 11)

They were thinking clearly and were not forced to sign it.

I also promise that:

- I know this person or they could prove who they were
- I am 18 years of age or older
- I am not their medical decision maker
- I am not their health care provider
- I do not work for their health care provider
- I do not work where they live

One witness must also promise that:

- I am not related to them by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after they die

Witness #1

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____ _____ _____ _____
address city state zip code

Witness #2

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____ _____ _____ _____
address city state zip code

You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes. To learn more go to www.prepareforyourcare.org

Developed by PREPARE™ for your care

Notary Public: Take this form to a notary public ONLY if two witnesses have not signed this form. Bring photo ID (driver's license, passport, etc.).

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California County of _____

On _____ before me, _____ , personally
Date Here insert name and title of the officer

appeared _____
Names(s) of Signer(s)

who proved to me the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct. WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

Description of Attached Document

Title or type of document: _____

Date: _____ Number of pages: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____

○ Individual
○ Guardian or conservator
○ Other_____

(Notary Seal)

For California Nursing Home Residents ONLY

Give this form to your nursing home director ONLY if you live in a nursing home. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

STATEMENT OF THE PATIENT ADVOCATE OR OMBUDSMAN

"I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code."

sign your name _____ date _____

print your first name _____ print your last name _____

address _____ city _____ state _____ zip code _____