

# Naples Premier Surgery Center

## Advance Directives Notice

### Advance Directive/Living Will/Healthcare Power of Attorney

I have an Advance Directive / Living Will / Healthcare Power of Attorney  YES  NO  
If yes, would you like to provide a copy for your medical record?  YES  NO

I would like to have information on Advance Directives  YES  NO  
If yes, I have received information regarding Advance Directives  YES  NO

### Acknowledgement of Receipt of Advance Directives

In certain cases, the patient's right to self-determination in making health care decisions may conflict with the center's stated policy of resuscitation in the event of life-threatening emergency. In order to assure that such situations are addressed and the patient's rights will be respected, twenty-four hours or more in advance to the elective surgery, the patient has received information regarding the procedures that will be implemented.

### Advance Medical Directive

I understand that in the event of an emergency that Naples Premier Surgery Center will initiate life-saving measures that may conflict with my desires as requested in an Advanced Directive or Living Will. I agree to proceed and have my elective surgery performed at this surgery center

\_\_\_\_\_  
Patient (or person authorized to sign for patient)

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness

Date: \_\_\_\_\_

If other than patient, please indicate relationship \_\_\_\_\_

and reason for signing in place of patient \_\_\_\_\_

Patient Name:

DOB: