Intracoastal
SURGERY CENTER LLC

## ADVANCED DIRECTIVE ACKNOWLEDGEMENT

I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). If I desire to exercise this right, I understand that I must inform my physician of my wishes. I understand that if I have a Living Will, Durable Power of Attorney, and/or Advanced Directive, I must inform **Intracoastal Surgery Center.** I am aware that in the event of a life-threatening emergency, it is the policy of **Intracoastal Surgery Center** to perform any necessary emergency procedures and transfer me to an acute facility/hospital for any additional care needed.

# PLEASE CHECK ONE

☐ I do not have an advance directive

**OR**

☐ I have an advanced directive and I have given **Intracoastal Surgery Center** a copy of such directive to remain on my medical record if transferred.

☐ I have an advanced directive and I have NOT given **Intracoastal Surgery Center** a copy.

☐ I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

I understand that I may revoke this consent ant any time by notifying **Intracoastal Surgery Center,** in writing, but if I revoke my consent, such revocation will not affect any actions that **Intracoastal Surgery Center** took before receiving my revocation.

______________________________________________

Signature of patient, patient's representative, or surrogate ____ Date and time

Printed Name of patient, patient's representative, or surrogate

Signature of witness ____ Date and time

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