



# PROVIDENCE SURGERY CENTER

## PATIENT CONSENT TO RESUSCITATIVE MEASURES

All Patients have the right to participate in their own health care decisions and to make advance directives or to execute powers of attorney that authorize others to make decisions on their behalf based on the Patient's expressed wishes when the Patient is unable to make decisions or unable to communicate decisions. This surgery center respects and upholds those rights.

**However, unlike in an acute care hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.**

It is our policy that if you have an advance directive, living will or health care power of attorney; you may consent to resuscitative measures if an adverse event occurs during your treatment at this facility. We will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation if allowed in your document or by this waiver. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney and hospital policy.

Please initial the appropriate box in answer to these questions. Have you executed an advance health care directive, a living will, a power of attorney that authorizes someone to make health care decisions for you?

\_\_\_\_\_ Yes, I have an advance directive, living will or health care power of attorney

\_\_\_\_\_ I DO NOT consent to resuscitative or stabilizing measures in case of an adverse event.

\_\_\_\_\_ I consent to resuscitative or stabilizing measures in the case of an adverse event

\_\_\_\_\_ No, I do not have an advance directive, living will or health care power of attorney

\_\_\_\_\_ I would like to have information on advance directives

If you checked the first box "yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

*BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THAT INFORMATION.*

BY: \_\_\_\_\_  
(PATIENT'S SIGNATURE)

PATIENT'S LAST NAME:

PATIENT'S FIRST NAME:

DATE:

If consent to the procedure is provided by anyone other than the Patient, this form must be signed by the person providing the consent or authorization.

*I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED.*

BY: \_\_\_\_\_  
(SIGNATURE)  
\_\_\_\_\_  
(PRINT NAME)

RELATIONSHIP TO PATIENT:

- PARENT OR COURT APPOINTED GUARDIAN
- ATTORNEY IN FACT
- HEALTH CARE SURROGATE
- OTHER \_\_\_\_\_



# PROVIDENCE SURGERY CENTER

INFORMATION PACKET

406-327-3300

[WWW.PROVIDENCESURGERY.COM](http://WWW.PROVIDENCESURGERY.COM)



## WELCOME .....

to the Providence Surgery Center. We would like to thank you for choosing this facility for your health care needs. Providence Surgery Center takes great pride in providing high quality health care for our patients.

Your physician has scheduled your upcoming surgical procedure to be performed at Providence Surgery Center. The Center is owned and operated by Providence Surgery Center, LLC, which is a limited liability company owned by local health care providers, one of whom may be your physician or physician's employer. The purpose of this notice is to advise you of this financial relationship and of your right to choose an alternative location for your procedure. If desired, please contact your surgeon or medical specialist to obtain a list of alternative surgical sites where he or she may have privileges to practice. This notice is being provided pursuant to federal laws and regulations relating to physician investments in out-patient surgery centers. The Members of our organization are listed below.

Saint Patrick Hospital  
Western Montana Clinic  
Missoula Anesthesiology  
Aesthetic Plastic Surgery  
John Harlan, MD  
David Allmacher, MD  
Gary Willstein, MD  
Jeffery LaPorte, MD  
Susan Tiede, DDS  
Garrick Simmons, MD  
Karl Westenfelder, MD  
O. Glenn Heyman, DO  
Patrick Danaher, MD  
Laurence Ayres, MD  
Kevin M. Kronner, MD  
Phillip A. Gardner, MD  
Christopher T. Caldwell, DO

If you have any questions please ask your physician or you may call Providence Surgery Center at 406-327-3300.

We look forward to meeting you.



## Before Procedure

- ✓ The pain clinic has given you instruction on when to be at Providence Surgery Center. Please bring the packet of information filled out at the time of your scheduled appointment.
- ✓ Please arrive one half hour before your procedure time unless instructed otherwise.
- ✓ You will need to arrange for a responsible adult to drive you home and it is recommended that someone stay with you for 24 hours.
- ✓ **IMPORTANT: Do not EAT anything EIGHT HOURS** before your procedure. This includes all foods, chewing tobacco, gum and hard candy. You may **DRINK clear liquids** (i.e. liquids you can see through) up to **FOUR HOURS** prior to your procedure. It is possible that your procedure would have to be cancelled if these instructions are not followed.
- ✓ Wear casual, loose clothing. Many people find jogging clothes and slip-on shoes are most comfortable.
- ✓ Please do not wear makeup, perfume, cologne or fingernail polish.
- ✓ Contact your insurance company for preauthorization and determine insurance status.
- ✓ Discuss with your physician your advanced directive if you have one.
- ✓ Please call your physician immediately if you become ill or are otherwise unable to keep your appointment.

## Day of Procedure:

- ✓ Take all regular medications, unless instructed to hold them for the procedure. You may take morning medications with a **small** sip of water (only enough water to swallow your pills with).
- ✓ If you are taking Lovenox temporarily instead of Coumadin, skip the dose for the day of the procedure.
- ✓ Leave valuables and all jewelry at home.
- ✓ Bring insurance cards and a photo ID.
- ✓ Bring Advanced Directives or Living Will with you.
- ✓ An IV may be placed so medications can be given before, during, and after procedure.

## After Procedure:

- ✓ You will be taken to the recovery room after your procedure and offered something to eat and drink. Family will be allowed to visit after your procedure. Recovery time will vary with

individuals. Due to space limitations, we ask that you bring no more than two family members/friends with you on your day of surgery.

- ✓ The nurse will review specific instructions given by your physician with you and the responsible adult who is to accompany you home, then escort you to the car.

## **At Home:**

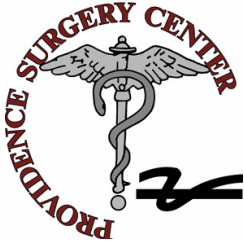
- ✓ Any sedation and pain medication can make you groggy and cause impaired judgment. Therefore, do not drive, operate hazardous machinery, make any important decisions, or sign legal papers for at least 24 hours.
- ✓ Do not drink alcohol for 24 hours.
- ✓ Resume normal medication as directed.
- ✓ Eat light foods for the first few hours after your procedure, then increase your diet as tolerated.
- ✓ Drink as much fluid as you can tolerate, up to 8 glasses/day.
- ✓ Call your physician with any concerns. The number to call is listed on your discharge instructions.

## **PATIENT'S RIGHTS & RESPONSIBILITIES**

- The PATIENT has the right to be treated with consideration, respect, and dignity.
- The PATIENT and/or the PATIENT REPRESENTATIVE have the right to all complete and current information concerning their diagnosis and treatment and in terms that he/she can understand. The PATIENT has the right to know the person or persons responsible for coordinating their care. If not medically advisable to give information to the patient, the information shall be made available to an appropriate person in the patient's behalf.
- The PATIENT has the right to receive from the physician enough information so that he/she may understand the services being rendered in order to sign the informed consent.
- The PATIENT has the right to refuse treatment and to be informed of the consequences of his/her actions.
- The PATIENT has the right to privacy of any information or treatment concerning his/her own medical care.
- The PATIENT has the right to be informed of any persons other than routine personnel that would be observing or participating in his/her treatment and to refuse that observation and/or participation.
- The PATIENT has the right for all medical records to be treated as confidential and given the opportunity to approve or refuse their release unless it would be cause a negative outcome in the continuation of medical care.
- The PATIENT has the right to information concerning the facility to which he/she may have to be transferred. The facility, that the patient is to be transferred to, must give approval prior to the patient transfer.
- The PATIENT has the right to know if any research will be done during his/her treatment and has the right to refuse it.
- The PATIENT has the right to expect quality care and service from Providence Surgery Center.
- The PATIENT has the right to be informed of the mechanism by which he/she will have continuing health care following discharge from Providence Surgery Center.
- The PATIENT has the right to examine and receive an explanation of their bill, regardless of the source of payment.
- The PATIENT has the right to know, in advance, the expected amount of his/her bill, regardless of the source of the payment.
- The PATIENT has the right to know what Providence Surgery Center Rules and Regulations apply to his/her conduct as a patient.

## PATIENT RESPONSIBILITIES

- It is the PATIENT'S responsibility to read and understand all permits and/or consents to be signed: Either ask the nurse or physician to clarify any information not understood about your care or services.
- It is the PATIENT'S responsibility to provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- It is the PATIENT'S responsibility to notify the Providence Surgery Center if you have a living will, medical power of attorney or other directive that could affect your care.
- It is the PATIENT'S responsibility to follow the treatment plan prescribed by his/her provide and to notify Providence Surgery Center on admission if pre-operative instructions have not been followed.
- The PATIENT is responsible for your actions if you refuse treatment or do not follow preoperative instructions.
- It is the PATIENT'S responsibility to provide adult transportation to and from Providence Surgery Center and remain with you for 24 hours, appropriate to the medications and/or anesthesia to be given and according to preoperative instructions.
- It is the PATIENT'S responsibility to follow the post-operative instructions given by the physician(s) and/or nurses. This includes instructions regarding post-operative appointments.
- It is the PATIENT'S responsibility to contact the physician if any complications occur.
- It is the PATIENT'S responsibility to assure all payments for service rendered are on a timely basis and ultimate responsibility is the patients, regardless of the insurance coverage.
- It is the PATIENT'S responsibility to provide financial and/or insurance information regarding who will be responsible for the bill including current address and authorized contact information.
- It is the PATIENT'S responsibility to notify the administration of Providence Surgery Center, if the PATIENT or the PATIENT REPRESENTATIVE thinks their right(s) have been violated or if the PATIENT has a significant complaint.
- It is the PATIENT'S responsibility and those accompanying the PATIENT to be respectful of all health care providers and staff, as well as other patients and follow the Center's policies.
- PATIENTS and/or PATIENT REPRESENTATIVES should contact the Office of the Medicare Beneficiary Ombudsman. [www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp) or the Montana Department of Health and Human Services, Certification Bureau at [www.dphhs.mt.gov/qadcomplaintprocedure](http://www.dphhs.mt.gov/qadcomplaintprocedure) or call (406) 44-2099; address Quality Assurance Division 2401 Colonial Drive PO Box 202953 Helena, MT 59620-2953 if they have a concern or complaint.



## NOTICE OF INFORMATION PRACTICES

Effective date:  
05/07/03

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Understanding Your Health  
Record/Information

Each time you visit an ambulatory surgery center, hospital, physician, or other healthcare provider, a record of your visit is made. At Providence Surgery Center (PSC) we are an integrated setting in which care is delivered by more than one health care provider/covered entity so this notice applies to more than one provider. This notice applies to all of the records of your care generated by the hospital, whether made by surgery center personnel or your personal doctor. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy; better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

### Your Health Information Rights

Although your health record is the physical property of Providence Surgery Center, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 *but we do not have to agree to accept your restrictions*
- obtain a paper copy of the Notice of Information Practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

### Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the surgery center. The notice will contain the effective date in the top right hand corner. In addition, each time you register at or are admitted to the surgery center for treatment or health care services, we will offer you a copy of the current notice in effect.

We will not use or disclose your health information without your authorization, except as described in this notice.

### For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the Medical Records Department at 406-327-3320.

If you believe your privacy rights have been violated, you can file a complaint with the Executive Assistant, the C.E.O. or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint

### **Examples of Disclosures for Treatment, Payment and Health Operations**

#### ***We will use your health information for treatment.***

**For example:** Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this surgery center.

#### ***We will use your health information for payment.***

**For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

#### **We will use your health information for regular health operations.**

**For example:** Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide

**Business Associates:** There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology,

certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

**Directory:** Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general conditions.

**Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**Funeral directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

**Organ procurement organizations:** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**Marketing:** We may contact you to provide appointment reminders or

information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Fund raising:** We may contact you as part of a fund-raising effort.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Workers compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Public health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

**Law Enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

# Billing Information

As a courtesy, Providence Surgery Center will bill your insurance on your behalf. We ask that you provide us with correct insurance information at the time of service. Providence Surgery Center requires you to make monthly payment in order to hold your account for six (6) months. At that time the remaining balance is due.

## Fees and Insurance

If you need more flexibility in paying your bill, you may be eligible for Care Credit which may extend the length of time to pay your balance. This arrangement is made by you. If interested, see the website below.

Care Credit [www.carecredit.com](http://www.carecredit.com)

Providence Surgery Center is a preferred provider for many insurances. However, to save you unexpected financial burden, we ask that you notify your insurance to preauthorized and verify eligibility for the procedure and for that procedure to be done at Providence Surgery Center. The insurance company can also tell you how much you have paid on your deductible and the amount to expect as your copay and responsibility. The number to call is located on the back of your insurance card.

### Links most often used:

Allegiance [www.abpmtpa.com](http://www.abpmtpa.com)

Blue Cross Montana [www.bcbsmt.com](http://www.bcbsmt.com)

Community Health Network [www.chnmt.com](http://www.chnmt.com)

Tricare [www.tricare.com](http://www.tricare.com)

First Choice [www.fchn.com](http://www.fchn.com)

Health InfoNet [www.healthinonetmt.com](http://www.healthinonetmt.com)

InterWest Health [www.interwesthealth.com](http://www.interwesthealth.com)

New West [www.newwesthealth.com](http://www.newwesthealth.com)

If you have any questions regarding your bill or billing information please call 327-3318.



902 North Orange St. Missoula, MT 59802 Phone (406) 327-3300 Fax (406) 327-3302

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Thank you for choosing Providence Surgery Center for your outpatient procedure. Your satisfaction is very important to us. After your visit you will receive a patient satisfaction survey in the mail. We hope you will fill out the survey and return it in the envelop provided. Please tell us how we did. All suggestions and comments are appreciated.

Thank you for your help.

Nancy Shooshtari, CEO

## **GRIEVANCE POLICY**

### **Submission and Investigation of Grievances**

You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's Decision.

The following are the names and/or agencies you may contact:

Providence Surgery Center  
902 North Orange Street  
Missoula, MT 59802

You may contact your state representative to report a complaint:

Montana State Auditor's Office  
840 Helena Avenue  
Helena, MT 59601  
(406) 444-2040  
1-800-332-6148 (MT)

Sites for address and phone numbers of regulatory agencies:

Medicare Ombudsman Web site: [www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp)

Medicare: [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227)

## **ADVANCE DIRECTIVES AND LIVING WILLS**

**This information is being provided to you for reference only and is not intended to provide legal advice.**

The Patient Self Determination Act was passed by Congress in 1990. The instrument for this Act and similar acts in individual states is called an Advance Directive. Health care institutions are required to tell patients about their rights under the law to make decisions about their health care – the right to accept or refuse care and the right to make Advance Directives about their health care were included in those Acts. It is emphasized that this information is provided as general information only and it is necessary for the patient to find out about the legal differences regarding the legal rights in the state where you live.

### **WHAT IS AN ADVANCE DIRECTIVE?**

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.

A good advance directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are.

Advance directives can take many forms. Laws about advance directives are different in each state. You should be aware of the laws in your state.

### **WHAT IS A LIVING WILL?**

A living will is one type of advance directive. It only comes into effect when you are terminally ill. Being terminally ill generally means that you have less than six months to live. In a living will, you can describe the kind of treatment you want in certain situations. A living will doesn't let you select someone to make decisions for you.

### **WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?**

A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

Living wills and DPAs are legal in most states. Even if they aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer or state representative about the law in your state.

### **SHOULD I HAVE AN ADVANCE DIRECTIVE?**

Most advance directives are written by older or seriously ill people. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

## HOW CAN I WRITE AN ADVANCE DIRECTIVE?

You can write an advance directive in several ways:

- Use a form provided by your doctor.
- Write your wishes down by yourself.
- Call your state senator or state representative to get a form.
- Call a lawyer.
- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

## CAN I CHANGE MY ADVANCE DIRECTIVE?

You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.

If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

## **You can obtain up to date Montana information about advance directives, along with statutory forms, if they exist in your state, from:**

Legal Counsel for the Elderly (LEC)  
American Association of Retired Persons  
P. O. Box 96474  
Washington, DC 20090-6474

LCE has state- specific guidebooks about advance directives. If you want to order a booklet, send \$5.00 per booklet (for shipping and handling) to the above address.

Or you may contact **Montana's End-of-Life Registry Department of Justice, Helena, Montana: phone 1-866-675-3314 or online at [www.EndofLife.gov](http://www.EndofLife.gov)** ; the American Association of Retired Persons (AARP) at 1-800-441-2277; or your attorney

## **What is a Health Care Advance Directive?**

A health care advance directive is a document in which you give instructions about your health if, in the future, you cannot speak for yourself. You can give someone you name (your "agent" or "proxy") the power to make health care decisions for you. You also can give instructions about the kind of health care you do or do not want.

In a Traditional Living Will, you state your wishes about life-sustaining medical treatments if you are terminally ill. In a Health Care Power of Attorney, you appoint someone else to make medical treatment decisions for you if you cannot make them for yourself.

Every state and the District of Columbia have laws that permit individuals to sign documents stating their wishes about health care decisions when they cannot speak for themselves. The specifics of these laws vary, but the principle of listening to the patient's wishes is the same everywhere. The law gives weight to any form of written directive. If the courts become involved, they usually try to follow the patient's stated values and preferences, especially if they are in written form. A Health Care Advance Directive may be the most convincing evidence of your wishes you can create.