



Family Health &  
Wellness Centers

**YOUR RIGHTS  
AND  
RESPONSIBILITIES  
AS A  
BMS FAMILY HEALTH  
AND WELLNESS CENTERS**

**PATIENT**

Adapted from the  
*New York State Department of Health Consumer Health Information Booklet*

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**Keep this booklet for reference.**  
***Review it carefully and share the information with your family and friends involved in your care.***

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## **II- Information Security and Patient Rights**

### **Privacy**

To ensure our patients' privacy, we always take the following precautions:

- Close cubicle curtains or doors to prevent patients from being embarrassed.
- Speak in low tones so that others cannot overhear patient information.
- Provide patients with the appropriate gown, blankets or other covering during transport or procedures.

### **Confidentiality**

At BMS, we are committed to ensuring patient confidentiality. We do not discuss any patient information with:

- One patient about another.
- Relatives and friends of a patient (unless officially authorized).
- Visitors to the health center.
- Representatives of the media.
- Other staff, except those involved in patients' care.
- Our relatives, friends, or neighbors.
- We never discuss the patient's information in elevators and corridors or where others can overhear.
- We look up patient information only if it is job-related.
- We do not leave patients' charts or reports where other patients can read them.
- We follow the Release of information policies and procedures.
- We check with the Medical Records Department if there are any questions about their policies and procedures.

When dealing with computerized patient information, we:

- Always use a unique log-on and password.
- Never share a log-on or password with another person.
- Turn computer monitors away from the direct view of patients or bystanders.
- Follow disaster recovery policies and procedures that are in place if computer information is lost.
- Ensure that computer access to patient information is determined based on job functions.

### **Patient Rights**

- Each patient in a health care facility in New York State has rights under the law; they are described in the section "Patients' Rights and Responsibility" later in this booklet. According to the Patients' Bill of Rights, a patient is viewed as an equal partner in the health care process and has the right to:
- A complete understanding of his or her diagnosis and treatment.
- Refuse treatment and know the consequences.
- Considerate and respectful care, without discrimination.
- Privacy and confidentiality.
- Complain about care without fear and receive a response.
- Appropriate assessment and treatment of pain.



### **III- Planning in Advance for Your Medical Treatment**

#### **Your Right to Decide About Treatment**

Adults in New York State have the right to accept or refuse medical treatment, including life- sustaining treatment. Our Constitution and state laws protect this right. This means that you have the right to request or consent to treatment, to refuse treatment before it has started and to have treatment stopped once it has begun.

Sometimes because of illness or injury, people are unable to talk to a doctor and decide about their treatment. You may wish to make plans in advance to make sure that your wishes about treatment will be followed if you become unable to decide for yourself for a short or long-time period. If you do not plan ahead, family members or other people close to you may not be allowed to make decisions for you and follow your wishes.

In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns. You have the right to appoint someone by filling out a Health Care Proxy (Form A). A copy of the form and information about the Health Care Proxy are attached.

If you have no one you can appoint to decide for you, or do not to appoint someone, you can also give instructions about treatment in advance. Those instructions can be written and are often referred to as an Advance Directive or a Living Will.

You should understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly cover the treatment decisions that must be made. For example, if you just write down that you don't want "heroic measures", the instructions may not be specific enough. You should specify the kind of treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition where you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope of recovering. You can also give instructions orally by discussing your treatment wishes with your doctor, family members or others close to you.

Putting things in writing is safer than simply speaking to people, but neither method is effective as appointing someone to decide for you. It is often hard for people to know in advance what will happen to them or what their medical needs will be in the future. If you choose someone to make decisions for you, that person can talk to your doctor and make decisions that they believe you would have wanted or that are best for you, when needed. If you appoint someone, you can leave instructions about treatment in a Living Will or in the space provided on the Health Care Proxy form itself, as a guidance to enable others to make the right decision for you.

**Deciding About Cardiopulmonary Resuscitation**

Your right to decide about treatment also includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is an emergency treatment to restart the heart and lungs when you're breathing, or circulation stops. Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the medical staff an order not to resuscitate (DNR order). If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family members, or others close to you can decide. A brochure on CPR and your rights under New York State law is available from one of our social workers.



## **MAKING DECISIONS ABOUT YOUR MEDICAL CARE**

### Information for Patients

This information is distributed in compliance with the federal law called the Patient Self-Determination Act. This law is designed, along with New York State law, to protect your rights to make decisions about your own medical care, including the right to accept or refuse treatment. You also have the right to appoint someone to make decisions for you if you cannot make them yourself.

As an adult, you have these rights:

- You have the right to choose what medical treatment you do or do not want now or in the future.
- You have the right to appoint someone to make your medical care decisions for you if in the future you cannot make those decisions for yourself.
- You can make your decisions about your care known, by telling your doctor or by putting your directions in writing.
- You can change your mind at any time.

The following pages show how you can make decisions about your medical care.



## MAKING DECISIONS ABOUT YOUR MEDICAL CARE

### WHY SHOULD I BE INVOLVED IN DECISIONS ABOUT MY MEDICAL CARE?

Your medical care affects you most of all, so you should be involved in any decision about your medical care.

### HOW CAN I BE INVOLVED IN DECISIONS ABOUT MY MEDICAL CARE?

Talk with your doctor or home health nurse about the choices you want to make. Ask questions and let those involved in your care know what your preferences are. Talk to them about what you want now but also talk to them about what you would want in the future if you ever became incapable of making your own health decisions. You can protect your rights by writing down your wishes and having two witnesses sign the statement. Such a statement is called an Advance Directive.

### WHAT IS AN ADVANCE DIRECTIVE?

An **Advance Directive** is a document in which you state what you want to be done if in the future you cannot make your own medical decisions. A document that gives specific directions to your doctor and others involved in your treatment is called a **Living Will**. In New York State, a document that appoints another adult to make health care decisions for you is called a **Health Care Proxy**. The **Health Care Proxy** can be used to both-appoint someone to make medical decisions for you and leave specific directions about your medical care.

### WHO DECIDES THAT I AM INCAPABLE OF MAKING HEALTH CARE DECISIONS?

By law, you are assumed to be capable of making health care decisions unless you, sometimes with the assistance of other doctors, decide that you are not capable of understanding the health care decisions you need to make or the risk and benefits of alternative decisions.

### WHO WILL MAKE HEALTH CARE DECISIONS FOR ME?

If you do not appoint someone, anyone involved in your care, or a court, could end up making decisions for you.

### WHO MUST FOLLOW WHAT I SAY IN MY ADVANCE DIRECTIVE?

It is the policy of BMS Family Health Center regardless of the contents of an Advance Directive or instructions from a Health Care Surrogate or Power of Attorney, that if an adverse event occurs during your treatment at the Health Center, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. If we have a copy of your Advance Directive we will send a copy of the document to the hospital. The acute care hospital will order further treatment measures in accordance with your wishes, Advance Directives or Health Care Power of Attorney.

### WHAT IF I DISAGREE WITH MY DOCTOR OR HOME HEALTH NURSE?

Your doctor and nurse will treat you according to what he or she believes is best for you. If you and your doctor or nurse cannot agree about your medical care, you may find another doctor or home health nurse.



## **WHAT SHOULD I SAY IN MY ADVANCE DIRECTIVE?**

You can say anything you want, but it is best to appoint someone and to discuss the following questions with that person. You can also put your feelings in writing in your Advance Directive.

- Do you want to be resuscitated if your breathing or heart stops?
- Do you want to be put on a breathing machine (ventilator or respirator) to restore your breathing if you are unable to breathe on your own?
- Do you want to be fed by tubes (receiving artificial nutrition and hydration) if you cannot be fed otherwise?
- Do you want medications, such as painkillers, even if they might make you die more quickly?

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

No, but it is good to have one so that those involved in your medical care will know what you want if you ever become incapable of making health care decisions for yourself.

## **HOW DO I WRITE AN ADVANCE DIRECTIVE?**

You can write your wishes on a piece of paper or ask us for a form. You should date the document, and two people must sign as witnesses.

## **WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE?**

You should give a copy to the person you appoint to make health care decisions for you, your doctor, your family, and anyone else that might be involved in making decisions about your medical care.

## **WHAT IF I WANT TO CHANGE MY ADVANCE DIRECTIVE?**

You can change or cancel your Advance Directive at any time. You can write a new Advance Directive, destroy the old one or tell those involved in your care that you have changed your mind. You should let anyone you told about your earlier wishes know that they have changed. It is particularly important to let your doctor or nurse know of any changes in your wishes.

## **HOW CAN I MAKE SURE MY ADVANCE DIRECTIVE IS LEGAL?**

Our form meets the requirements of New York law. If you follow the directions on that form, your Advance Directive should be legal in New York State. You can also have a lawyer help you draft your Advance Directive or review the ones you have drafted. At this point, no Advance Directive form is valid in all 50 states.

## **WHAT IF I NEED MORE INFORMATION ABOUT ADVANCE DIRECTIVES?**

Ask us and we will try to answer your questions or refer you to someone who can help. You can make an appointment with one of our social workers if you'd like more information. If you are interested in receiving more information, please complete Form B at the back of this booklet and give the booklet to the Registration Clerk.



## **Patients' Rights and Responsibilities**

**As a patient at the BMS Family Health and Wellness Centers, a health care facility in New York State, you have the right, consistent with law, to:**

1. Understand and use the rights and responsibilities during your visits to the Health Center and satellite facilities. If for any reason you do not understand or you need help, the Health Center **MUST** provide assistance, including an interpreter.
2. Receive prompt and efficient medical care, and to be able to schedule an appointment within a reasonable time.
3. You are responsible for keeping all scheduled appointments for regular visits, for follow-up testing, and specialty care; and for canceling appointments that you are not able to keep before their scheduled time.
4. You are responsible for providing, to the best of your knowledge:
  - i. Accurate information about your symptoms including pain, medications, previous illness, previous surgeries, allergies, etc.
  - ii. Information about any unexpected changes in your condition.
  - iii. Feedback as to whether you understand all the information that has been discussed with you.
5. In all matters concerning your care at the Health Center, you have the responsibility to ask questions about anything that you do not understand, and to obtain further clarification if needed.

**You have the right, consistent with the law, to:**

6. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.
7. Receive considerate and respectful care in a clean and safe environment free of unnecessary barriers or restraints.
8. Receive appropriate assessment and management of pain.
9. Receive emergency care if you need it.
10. Be informed of the name and position of the health care practitioner, who will be in charge within the Health Center.
11. Know the names, positions, and functions of any Health Center staff involved in your care and refuse their treatment, examination, or observation.
12. A smoke-free environment. (Please note that no smoking is allowed anywhere within the Health Center.)
13. Receive complete information about your diagnosis (condition), treatment and prognosis (expected health outcome).
14. Receive all the information that you need to give informed consent for any proposed procedure or treatment, including the possible risks and benefits of the procedure or treatment. You are responsible for providing consent for medically agreed-upon treatment.
15. Receive all the information you need to give informed consent for an order not to be resuscitated. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please speak with your health care practitioner, the Unit Nurse Supervisor, or a member of the Social Services staff.



16. Refuse treatment and be told what effect this may have on your health.
17. Refuse to take part in the research. In deciding whether or not to participate, you have the right to a full explanation.

**You have the right, consistent with law, to:**

18. Privacy while in the Health Center and, consistent with the provisions of the Health Information Portability and Accountability Act. (HIPAA), the confidentiality of all information and records, regarding your care.
19. Participate in all decisions about your treatment and referrals from the Health Center.
20. Schedule a review of your medical record without charge.
21. Obtain a copy of your medical record for which the Health Center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
22. Receive an itemized bill and explanation of all charges.
23. Complain without fear of reprisals about the care and services you are receiving and have the health center respond to you. You have the right to a written response if you request it. If you are not satisfied with the health care center's response, you can complain to the New York State Department of Health. The Health Center must provide you with the Health Department's telephone number.
24. Make known your wishes regarding anatomical gifts. You may document your wishes in your health care proxy form or living will, available at Registration or through our Social Services staff.

**Additionally...**

- Please be respectful of the property of BMS and of other persons who are in attendance at the Health Center. Please be considerate of the rights of other patients and Health Center personnel.
- You are responsible for helping to keep your area and your child's area clean. Please keep your children with you at all times.
- You are a partner in wellness and illness prevention with your health care practitioner. Please keep your treatment plan and immediately report any adverse reaction to medication.
- You are responsible for addressing all bills promptly. If you have difficulty regarding a bill, please seek assistance from the Health Center Staff
- As soon as possible after an occurrence, please report any hospitalization or treatment at the Emergency Room to your health care practitioner.



## **Appointing Your Health Care Agent**

### **NEW YORK STATE'S PROXY LAW**

A law called the New York health care proxy law allows you to appoint someone you trust -for example, a family member or close friend - to decide about treatment if you lose the ability to decide for yourself. You can do this by using a Health Care Proxy form like the one inside, to appoint your "health care agent."

This law gives you the power to make sure that health care professionals follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors, and other health care providers must follow your agent's decisions as if they were your own.

You can give the person you select, your health care agent, as little or as much authority as you want. You can allow your agent to decide about all health care or only certain treatments. You may also give your agent instructions that he or she has to follow.

#### **Why should I choose a health care agent?**

If you become too sick to make health care decisions, someone else must decide for you. Health care professionals often look to family members for guidance. But family members are not allowed to decide to stop treatment; even if they believe that is what you would choose or what is best for you under the circumstances. Appointing an agent lets you control your medical treatment by:

- Allowing your agent to stop treatment when he or she decides that is what you would want or what is best for you under the circumstances.
- Choosing one family member to decide about treatment because you think that person would make the best decisions or because you want to avoid conflict or confusion about who should decide; and
- Choosing someone outside your family to decide about treatment because no one in your family is available or because you prefer that someone other than a family member decide about your health care.

#### **How can I appoint a health care agent?**

All competent adults can appoint a health care agent by signing a form called a Health Care Proxy. You do not need a lawyer, just two adult witnesses. You can use the form printed here, but you do not have to

#### **When would my health care agent begin to make treatment decisions for me?**

Your health care agent will begin to make treatment decisions after doctors decide that you are not able to make health care decisions. As long as you are able to make treatment decisions for yourself, you will have the right to do so.

#### **How will my health care agent make decisions?**

You can write instructions on the proxy form. Your agent must follow your oral and written instructions, as well as your moral and religious beliefs. If your agent does not know your wishes or beliefs, our agent is legally required to act in your best interests.

**What decisions can my health care agent make?**

Unless you limit your health care agent's authority, your agent will be able to make any treatment decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose between different treatments, and decide that treatments should not be provided, in accordance with your wishes and interests.

If your health care agent is not aware of your wishes about artificial nutrition and hydration (nourishment and water provided by feeding tubes), he or she will not be able to make decisions about these measures. Artificial nutrition and hydration are used to continue the life of patients who are in a permanent coma.

**Who will pay attention to my agent?**

All hospitals, doctors and other health care facilities are legally required to honor the decisions by your agent. If a hospital objects to some treatment options (such as removing certain treatments) they must tell you or your agent in advance.

**What if my health care agent is not available when decisions must be made?**

You can appoint an alternate agent to decide for you if your health care agent is not available or able to act when decisions must be made. Otherwise, health care providers will make treatment decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

**Where should I keep the proxy form after it is signed?**

Give a copy to your agent, your doctor and any other family members or close friends you want. You can also keep a copy in your wallet or purse or with other important papers.

**What if I change my mind?**

It is easy to cancel the proxy, to change the person you have chosen as your health care agent or to change any treatment instructions you have written on your Health Care Proxy form. Just fill out a new form. In addition, you can require that the Health Care Proxy expire on a specified date or if certain events occur.

Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent and you get divorced or legally separated, the appointment is automatically canceled.

**Can my health care agent be legally liable for decisions made on my behalf?**

No. Your health care agent will not be liable for treatment decisions made in good faith on your behalf. Also, he or she cannot be held liable for the costs of your care, just because he or she is your agent.

**Is a health care proxy the same as a living will?**

No. A living will is a document that provides specific instructions about health care treatment. It is generally used to declare wishes to refuse life-sustaining treatment under certain circumstances.

In contrast, the health care proxy allows you to choose someone you trust to make treatment decisions on your behalf. Unlike a living will, a health care proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made. The health care proxy is just as useful for decisions to receive treatment as it is for decisions to stop treatment. If you complete a Health Care Proxy form, but also have a living will, the Living Will provides instructions for your health care agent and will guide his or her decisions.



**APPOINTING A HEALTH CARE AGENT IS A SERIOUS DECISION. MAKE SURE YOU TALK ABOUT IT WITH YOUR FAMILY, CLOSE FRIENDS, AND YOUR DOCTOR.**

Do it in advance, not just when you are planning to enter the hospital.

Filling out a health care proxy is voluntary. No one can require you to do so.

## **PROXY FORM INSIDE**

**THE HEALTH CARE PROXY LAW TOOK EFFECT IN JANUARY 1991; FORMS SIGNED BEFORE THAT DATE ARE VALID.**



## About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service, or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. You do not need a lawyer to fill out this form.

You can choose any adult (over 18), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your

attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask the staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

If I become terminally ill, I do/don't want to receive the following treatments: ...

If I am in a coma or unconscious, with no hope of recovery, then I do/don't want ...

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want ...

I have discussed with my agent my wishes about \_\_\_\_\_ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may leave instructions.

- Artificial Respiration
- Artificial Nutrition and Hydration



(Nourishment and Water Provided by Feeding Tube)

- Cardiopulmonary Resuscitation (CPR)
- Antipsychotic Medication
- Electric Shock Therapy
- Antibiotics
- Psychosurgery
- Dialysis
- Transplantation
- Blood Transfusions
- Abortion
- Sterilization

### **Filling Out the Proxy Form**

Item (1) Write your name and the name, home address and telephone number of the person you are selecting as your agent.

Item (2) If you have special instructions for your agent, you should write to them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all

health care decisions that you could have made, including the decision to consent to or refuse life sustaining treatment. You may also state your wishes about organ or tissue donation(s).

Item (3) You may write the name, home address and telephone number of an alternate agent.

Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses at 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.



## FORM A

# PLEASE COMPLETE THIS FORM AND GIVE THE WHOLE BOOKLET TO REGISTRATION CLERK

## Health Care Proxy

I, \_\_\_\_\_ - hereby appoint

\_\_\_\_\_  
(Name, Home Address and Telephone Number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions

Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

\_\_\_\_\_  
\_\_\_\_\_  
(Unless your agent knows wishes about artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on the reverse for samples of language you could use.)

Name of substitute or fill-in agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent.

\_\_\_\_\_  
(Name, Home Address and Telephone Number)

Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific dates or conditions, if desired):

Signature \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

Statement by Witness (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 \_\_\_\_\_

Address \_\_\_\_\_

Witness 2 \_\_\_\_\_

Address \_\_\_\_\_



## FORM B

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

### ACKNOWLEDGMENT OF PATIENT RIGHTS INFORMATION

In accordance with the New York State Department of Health and Federal Law Part 405.7, the above-named patient has received a booklet on "YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT."

The booklet is divided into two sections:

Section I: Explains your rights as a hospital/health center patient in New York State.

Section II: Presents each document that the law requires you to receive as a patient in a hospital/health center in New York State.

The affixed signature of the patient or patient's significant other, and the health center representative are evidence that the above information was given to the patient. In addition, I have been informed that BMS Family Health and Wellness Centers is a non-smoking facility.

#### COMMENTS:

A. Patient has an Advance Directive	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Copy placed on chart <input type="checkbox"/> Patient/Family/Other requested to bring in <input type="checkbox"/> Re-done	
B. Patient is requesting further explanation on Advance Directive	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Patient would like to execute an Advance Directive	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### FOLLOW-UP:

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SIGNATURE OF PATIENT:

NAME OF BMS REPRESENTATIVE (**PRINT**):

SIGNATURE OF BMS REPRESENTATIVE: