HMG
HOLSTON MEDICAL GROUP

Welcome to our office

Where did you hear about us?
❒ Yellow Pages (YP) ❒ Newspaper (NP) ❒ Website (WS)
❒ Friend or Family (FF) ❒ Physician Referral (PR)
❒ Other (OT) _____

OFFICE USE ONLY
Physician: _____
Approved by: _____
Date: _____

NEW PATIENT INFORMATION (Complete if different from billing party)

Name _____
First Middle Last

Address _____

City _____ State _____ Country _____ Zip _____ Phone # (____) _____

Birthdate _____ Sex M or F Race _____ Marital Status S M W D

Social Security # _____ Employer _____

Address of Employer _____ Work Phone # _____

May we contact you at work? Y N By E-Mail Y N E-Mail Address _____

Emergency Contact Name _____ Emerg. Phone # (____) _____

Relationship to billing party _____

Guarantor/Responsible Party

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____ Phone # _____

Birthdate _____ Sex M or F Marital Status S M W D

Social Security # _____ Driver's License # _____

Place of employment _____ Work Phone # _____

OTHER INFORMATION

Name and address of nearest relative not living with you _____

Address _____ City _____ State _____ Zip _____ Phone # _____

If you are currently under another physician's care, please list:

Name _____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to us? _____

INSURANCE

1. Primary Insurance Company Name _____

Group # _____ Policy Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

2. Secondary/Supplemental Insurance Name _____

Group # _____ Policy/Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.
By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:
I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date _____ Signature _____

Seasons
Comprehensive women's health solutions for every season of life.

Date:_____

Name_____ Age _____ DOB_____

Chart Number _____ Referred by _____

Thank you for choosing Seasons Comprehensive Women's Health as your female healthcare provider.
We will always strive to meet your needs and provide quality care with kindness, understanding, and courtesy.

Have you had any of these symptoms in the last year? Check "Yes" or "No"

GENERAL	Yes	No	**CHEST**	Yes	No	NOTES
fever			cough			
chills			pain			
changes in weight			shortness of breath			
fatigue			sputum production			
sweats			coughing up blood			
history of anemia			**HEART**			
bleeding tendencies			pain			
SKIN			palpitations			
rashes			history of a heart murmur			
hives			(any antibiotics for the murmur?)			
easy bruising			**VASCULAR**			
previous skin disorders			pain in legs			
history of eczema			swelling of the legs			
abnormal moles			**BREASTS**			
HEAD			lumps			
headaches			discharge			
fainting			pain or tenderness			
history of head injury			**GASTROINTESTINAL**			
EYES			constipation			
changes in vision			diarrhea			
recent eye exam			nausea			
redness			vomiting			
discharge			rectal bleeding			
history of glaucoma			abdominal pain			
cataracts			**URINARY**			
EARS			frequency			
hearing impairment			Urgency			
pain			leaking of urine			
ringing in ears			blood in urine			
NOSE			FEMALE GENITALIA			
frequent nosebleeds			spots on outside of vagina			
sinus infections			discharge			
hay fever			pain with intercourse			
discharge			using birth control			
NECK			infertility problems			
lumps			history of DES exposure			
pain with movement			menstrual pain			
history of "swollen glands"			hot flashes or night sweats			
NEUROLOGIC			bleeding after menopause			
fainting			**MUSCULOSKELETAL**			
loss of memory			weakness			
mood changes			arthritis			
nervousness			joint pain			
disorientation						

Please answer the following questions about your medical history:

PAST MEDICAL HISTORY	YES	NO	PHYSICIANS NOTES ONLY
High blood pressure?			
Diabetes?			
Asthma?			
Depression?			
Other Problems ? List			
1.			
2.			
3.			
PAST SURGICAL HISTORY			
Hysterectomy?			
Gallbladder?			
Appendectomy?			
Laparoscopy?			
Tubes tied?			
Other Surgeries? List			
1.			
2.			
3.			
FAMILY HISTORY			
High Blood Pressure?			
Heart Disease?			
Diabetes?			
Kidney Disease?			
Thyroid Disease?			
Intellectual Disability?			
Multiple Miscarriages?			
Other Diseases? List			
1.			
2.			
3.			
CANCERS IN THE FAMILY			
Breast?			
Ovarian?			
Uterine?			
Cervical?			
Colon?			
Lung?			
Other Cancers? List			
1.			
2.			
3.			

Pregnancy History: How many times have you been pregnant _____

Number of babies born full term_____ Born prematurely_____

Number of Miscarriages_____ Abortions_____ Number of tubal/ectopic pregnancies_____

Number of living children_____ (G_____ P_____)

Medications (dosage and frequency_____

_____

_____

Allergies to medications (note reactions)_____

_____

Are you on any vitamins or herbal supplements ❒ Yes ❒ No If yes, please List name, dosage and frequency_____

_____

Gynecologic History:

When was your last pap smear done and where_____

Have you ever had an abnormal pap smear ❒ Yes ❒ No

If yes, what further tests or treatments did your have? (Please check)

❒ Repeat Pap ❒ Colposcopy ❒ Cryosurgery ❒ LEEP ❒ Conization ❒ None

Are you currently using birth control and which type_____

Have you ever had any sexually transmitted disease (Please check)

❒ Gonorrhea ❒ Chlamydia ❒ Syphilis ❒ Warts ❒ Trichomonas ❒ Herpes ❒ HIV ❒ None

When was your last menstrual period_____ (LMP ____/____/____)

At what age did your first period start_____ Years Old

Are your periods (Please check) ❒ Regular ❒ Irregular ❒ Not having periods ❒ Hysterectomy

Have you ever had a mammogram and where?_____

Social Health:

Have you changed your occupation lately? ❒ Yes ❒ No

Do you have any problems at home? ❒ Yes ❒ No

Do you have relationship problems? ❒ Yes ❒ No

Are there any personal issues you would like to discuss? ❒ Yes ❒ No

Do you smoke? ❒ Yes ❒ No ❒ Quite (When)_____

If yes, how many cigarettes per day?_____

Do you drink alcohol? ❒ Yes ❒ No

If yes, how many drinks per day? ❒ <1 ❒ 1-3 ❒ 4-5 ❒ >5

Have you ever used street drugs? ❒ Yes ❒ No

If yes, what did you use_____

When did you last use it_____

Have you ever had a problem with alcohol or drugs? ❒ Yes ❒ No

Clinical Research: Would you be interested in learning more about Season's Clinical Research Trials? ❒ Yes ❒ No

We have a coordinator available on site or you may call (423) 844-4939 for further information.

* * * * * STOP * * * * * *

PHYSICIANS USE ONLY PAST THIS POINT

Other History_____

_____

_____

_____

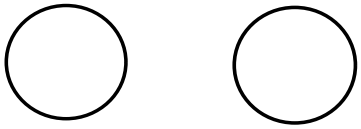
_____

PHYSICAL EXAMINATION:

Vital Signs, BP_____ HR_____ RR_____ Temp _____ Urine_____

EXAM	Normal	Abnormal Findings
General		
Head		
Face		
Eyes		
Nose		

DO NOT FILL OUT / PHYSICIAN USE ONLY

Exam	Normal	Abnormal
Ears		
Mouth		
Neck		
Thyroid		
Lymph Nodes		
Chest		
Heart		
Lungs		
Breasts		
Axilla		
Abdomen		
Hernia		
Musculoskeletal		
Neurologic		
Reflexes		
Skin		
Lymphatic		
Pelvic Exam		
Vulva		
Bartholin's Gland		
Urethra		
Skene's Gland		
Vagina		
Cervix		
Pap Smear Done		
Bimanual Exam		
Uterus		
Adnexa		
Rectovaginal		
Sphincter		
Hemorrhoids		
Hemmoccult		
Other		

Assessment/Plan

Seasons
Comprehensive women's health solutions for every season of life.

Abingdon / Bristol / Kingsport

Patient's Name _____ **MRN** _____

CONSENT FOR TREATMENT

1. **General Consent for Treatment and Tests:** I consent to treatment by Seasons Comprehensive Women's Health's physicians and staff for my illness and/or health evaluations including but not limited to x-rays, blood tests, laboratory procedures, medications, and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my medical care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

2. **Independently Practicing Doctors:** I understand and agree that most of the radiologists, pathologists, anesthesiologists, and some allied health professionals are engaged in the practice of their professions on behalf of themselves or other corporations. I hereby authorize payment directly to these physicians the insurance benefits otherwise payable to me, but not to exceed the total charges due to the physicians. I also authorize the release of any medical information necessary to process these insurance claims.

3. **Release from Liability for Leaving Against Medical Advice:** I agree that if I leave a physician's office against the advice of my physician or Seasons Comprehensive Women's Health medical staff, that Seasons Comprehensive Women's Health, its personnel, and my physician(s) are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice.

4. **Authorization to Release Medical Information:** I authorize Seasons Comprehensive Women's Health and all physicians involved in my care to disclose and release my medical information (which may include alcohol and drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare intermediaries and fiscal agents.

I have read and understand this document and agree to the terms.

_____ _____

Signature of Patient/Authorized Party | Relationship

_____ _____

Signature of Witness | Date

MRN: _____

DATE RECEIVED: _____

No Show Policy

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least 24-hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients who fail to show up for a scheduled appointment may be charged a fee for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

_____ _____

Please Print Patient Name Date of Birth

_____ _____

Patient Signature / Authorized Representative Relationship to Patient

_____ _____

Witness Date

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
. ان ت باه : إذا ك نت ب حاجة إل ى خدمات ال ل غة أو ال ترجمة، ي رجى أن ت ط لب ال تحدث مع مدي ر م ك تب

Revised:

HMG
HOLSTON MEDICAL GROUP

Seasons

MRN: _____

Date Received: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices,* which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

_____ _____

Print Patient Name | Patient Date of Birth

_____ _____

Patient Signature (if applicable) | Date

_____ _____

Authorized Representative Signature | Relationship to Patient

---

I understand that my Protected Health Information (PHI) will only be <u>verbally</u> communicated to those individuals listed below and no paper copies of my PHI will be provided without my signature on an *Authorization for Release of Individually Identifiable Health Information* form. I understand that some information may be considered sensitive, including but not limited to pregnancy test results, testing for sexually transmitted infections, Urine Drug Screen results, laboratory test results, medication, or information discussed during an office visit. The individuals listed below, will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individual(s) that you want protected health information verbally discussed with:

Name	Phone Number	Name	Phone Number

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained: _____

_____ _____

Employee Signature | Date

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Atención: Si necesita servicios de idioma o traducción, solicite hablar con el Gerente de Oficina

نبيه: إذا كنت بحاجة إلى خدمات اللغة أو الترجمة، فيرجى طلب التحدث مع مدير المكتب

Comprehensive women's health solutions for every season of life.

Patient: ______________________________

MRN: ______________________________

Communicating with Seasons
Obstetrics & Gynecology

Access to Your Physician and Staff

Your Seasons health care team can be reached either by telephone or electronically through our patient portal, FollowMyHealth®. If you wish to communicate electronically, you may sign up at any office location on our website at your convenience. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **<u>is not</u>** appropriate to communicate with your health care team through social media, such as **Facebook**, or **texting**. Your privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

After Hours Care

Seasons is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. For further instructions on how to contact the Seasons Physician on Call, please contact your Seasons office directly.

Kingsport – (423) 247-7500 Bristol – (423) 844-1399

Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 48 hours for all refill request before checking with your pharmacy.

Sample medication will only be distributed during normal business hours.

Signature: ______________________________ **Date:** ________________

Witness: ______________________________ **Date:** ________________

FINANCIAL POLICY

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

1. **PAYMENT** is expected at the time of your visit. Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. ***We will accept cash, check, debit, credit or health savings accounts***. You may also make a payment online through our patient portal, FollowMyHealth®.

   Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause payment in full is expected at the time of your visit. For visits under a "global" or a follow up trauma visit (from a procedure performed by an HMG physician) or for ongoing rehabilitation treatment plans, you will only be responsible for your co-payment if applicable based on your insurance. We do ask for a ***copy of your current insurance card*** at the time of your visit to ensure we properly file your claim.

2. **SURGERY PATIENTS:** You may be responsible or required to pay a percentage of surgery charges prior to any surgeries or procedures. This will be determined by information given to us by your insurance company in regard to patient percent responsibility.

3. **INSURANCE:** We participate with several insurance plans and will file your claims on your behalf. It is your responsibility to ensure coverage for services prior to your visit. You will be responsible for the complete charges for any non-covered services provided. In addition, all co-payments, deductibles or non-covered charges will be due at the time of service.You must provide proof of insurance at each visit so we can ensure proper billing to your benefit plan. If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance(s). We do not bill third party payors, but will be happy to provide a copy of the original claim if requested.

4. **HIGH-DEDUCTIBLE PLANS:** Under these plans, your insurance company will provide you a discount off our billed charges, but you are responsible for the entire amount due until you meet your deductible. ***We will accept cash, check, debit, credit or you may use your health savings account***.

5. **RETURNED CHECKS** will incur a $30.00 service charge.

6. **ACCOUNTING PRINCIPLES:** If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance (s). Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service

7. **FORMS FEES:** Medical records, except those involving worker's compensation cases, will be billed at the rates listed below:

   Simple Forms (completed within 2 business days)
   DURING an office visit: No Charge
   AFTER an office visit: $5 / form
   Examples of Simple Forms: Handicap tag/sticker, work re-entry forms, immunization, medication, sports, concussion clearance, WIC, Home Bound Status Short form, Disability Short Form, Bank Loan Form, Foster Parent Health Form, College & Camp Forms

   Complex Forms: $25 (completed within 10 business days)
   Examples of Complex Forms: FMLA (per illness per year), Disability Long Form, Home Bound Status Long Form.

FINANCIAL POLICY

8. **MISSED APPOINTMENTS:** If you fail to cancel a previously scheduled appointment at least 24 hours in advance, you may be charged a fee as outlined below:

- Established office visit: $20
- Allergy Testing: $75
- New patient visit or consultation: $100
- GI Procedure: $250

This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts. This charge is not applicable to patients with Medicaid/TennCare insurance coverage.

After 2 no-show appointments in a rolling calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

9. **UNPAID BALANCES:** All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency and could affect your credit.

10. **FINANCIAL DISMISSAL**: Patients who do not make payment arrangements risk being dismissed from the practice. Holston Medical Group reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

11. **BILLING QUESTIONS:** We will be happy to help you resolve your balance and can be reached at **(423) 578-1802, Monday – Friday 8:00AM – 5:00PM.**

HMG
HOLSTON MEDICAL GROUP

FINANCIAL POLICY

MRN#: _____

Date Received: _____

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

I have read, understand and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service are my responsibility.

I authorize Holston Medical Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Holston Medical Group.

By signing below, I indicate my agreement with the policy as provided to me.

_____	_____	_____
Date	**Signature**	**Printed Name**

ADVANCE DIRECTIVES

What happens if you become too sick to make your own decisions regarding your medical care? Your family and doctor must decide what treatment to use, when not to treat, and/or when to stop treatment. Your family may not know what you would desire or may not agree on what would be best for you. It is best if they are aware of what you would desire and who you want to make these decisions on your behalf.

With the enactment of a federal law, The Patient Self-Determination Act, you have the right to make decisions about your future health care. This includes the right to accept or refuse medical or surgical treatment and to place and direct the types of health care you may receive if you become unable to express your wishes. You can exercise this right by making an Advance Medical Directive.

Different providers have, in accordance with the state law, varying practices regarding the implementation of an advance directive. Information regarding such practices must be made available to you, upon request, when selecting or receiving care from the provider.

If your physician, as a matter of conscience, is unable to comply with your directives, he/she must take all reasonable steps to arrange to transfer you to another physician.

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive explains, in writing, your choices about the treatment you want or do not want, or about how health care decisions will be made for you if you are too ill to express your wishes.

An advance directive expresses your personal wishes and is based upon your beliefs and values. When you make an advance directive, you will consider issues like dying, living as long as possible, being kept alive on machines, being independent, and the quality of your life.

Use of an Advance Medical Directive makes it possible for your wishes to be carried out during a serious illness.

If you are an adult and of “sound mind”, you can make an advance directive.

There are two types of formal advance directives. You can complete either a Living Will, a Power of Attorney for Health Care, or both.

LIVING WILL

A Living will informs your physician that you want to die naturally if you develop an illness or injury that cannot be cured. It tells your physician that, when you are near death or in a vegetative state, he or she should not use life-prolonging measures which postpone, but do not prevent, death.

A Living Will allows you to refuse treatments or machines which keep your heart, lungs, or kidneys functioning when they are unable to function on their own.

POWER OF ATTORNEY FOR HEALTH CARE

The Power of Attorney for Health Care is a form that you may complete to appoint another person (a “health care agent’) to make health decisions for you if you are not capable of making them yourself.

MAINTAINING YOUR ADVANCE DIRECTIVE

You should review and update your advance directive periodically. You have the right to change or discontinue your directive at any time. You should keep your advance directive in a safe place where you and others can easily find it. (Do not keep it in a safety deposit box.) You should make sure your family members and your lawyer, if you have one, know you have made an advance directive and know where it is located. Be sure your physician has a copy of your directive in your medical file.

WILL ALL STATES RECOGNIZE MY DIRECTIVES?

If you plan to spend time in a state other than your state or residence, from which you obtained your Advance Medical Directives, you may wish to execute advance directives in compliance with that state’s laws as well.

Specific question should be directed to your physician and/or attorney for guidance.

Follow the instructions provided by your state when completing the Advance Directives forms.

To obtain additional information, brochures, or forms, you may write to the address below:

Tennessee Commission on Aging
Nashville, Tennessee 37243-0860

I have read and understand the above:

Name: _____

Signature: _____ Date: _____

Date of Birth: _____ MRN: _____

VIRGINIA ADVANCE MEDICAL DIRECTIVE

This form, with slight variations, is the form approved by the Virginia General Assembly in the Health Care Decisions Act. The form contains a "Living Will" portion, a portion in which you may appoint an agent to make health care decisions for you, and a portion in which you may appoint an agent to make an anatomical gift. You may complete any on or all of these portions of the form. Virginia law does not require the use of this particular form in order to make a valid advance directive. If you have legal questions about this form, or would like to develop a different form to meet your particular needs, you should talk with an attorney. You must sign your advance medical directive in the presence of two witnesses who are not blood relatives or your spouse. It is your responsibility under Virginia law to provide a copy of your advance directive to your attending physician. You also should provide copies of the directive to close relatives and/or friends.

ADVANCE MEDICAL DIRECTIVE made this _____ day of _____, _____.
Month Year

I, _____, willfully and voluntarily make known my desire and do hereby declare:

(Cross through this box if you do not want to make a living will in this form.)

"Living Will" Portion of Advance Medical Directive

If at any time my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. (OPTION: I specifically direct that the following procedures or treatments be provided to me: _____
_____

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

(Cross through this box if you do not want to appoint an agent to make an anatomical gift or organ, tissue or eye donation for you.)

Appointment of Agent to Make Anatomical Gift

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donation may be made pursuant to applicable Virginia law governing anatomical gifts and in accordance with my directions, if any. I hereby appoint _____ as my agent, of
_____
Address Phone Number

to make any such anatomical gift or organ, tissue or eye donation following my death.

I further direct that: _____
(Declarant's directions, if any, concerning anatomical gift or organ, tissue or eye donation)

(Cross through this box if you do not want to appoint an agent to make health care decisions for you.)

Appointment of Agent to Make Health Care Decisions

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document:

_____

Primary Agent Telephone Number

_____

Address

If the above named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as successor agent to serve in that capacity:

_____

Successor Agent Telephone Number

_____

Address

I hereby grant to my agent, named above, full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment. The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed medical decision or unable to make a rational evaluation of the risks and benefits of a proposed medical decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way. My agent's authority hereunder is effective as long as I am incapable of making an informed decision.

The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. Such certification shall be required before treatment is withheld or withdrawn, and before, or as soon as reasonably practicable after, treatment is provided, and every 180 days thereafter while the treatment continues.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or nontreatment. My agent shall not authorize a course of treatment which he knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what treatment choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he believes to be in my best interest.

Further, my agent shall not be liable for the costs of treatment pursuant to his/her authorization, based solely on that authorization.

OPTION: Powers of my agent. (Cross through any language you do not want and add any language you do want.)

The powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including but not limited to artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastens my death:

B. To request, receive, and review any information, verbal or written, regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information;

Appointment of Agent to Make Health Care Decisions, Part II

C. To employ and discharge my health care providers;
D. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, adult home or other medical facility for services other than those for treatment of mental illness requiring admission procedures provided in Article 1 (37.1-63 et seq.) of Chapter 2 of Title 37.1;
E. To make decisions about whom may visit me, subject to physician orders and policies of any institution to which I am admitted.
F. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

_____

_____

_____

This advance directive shall not terminate in the event of my disability. By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

_____ _____

Date Signature of declarant

The declarant signed the foregoing advance directive in my presence. I am not the spouse or a blood relative of the declarant.

_____

Witness

_____

Witness

State of Virginia Declaration Form

Declaration made this _____ day of _____ (month/year.) I, _____ willfully and voluntarily make known my desire and do hereby declare:

You must choose between the following two paragraphs. #1 designates a person to make a decision for you. #2 , you make all decisions. Cross through the paragraph you do NOT want.

#1: If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition, my death is imminent, and I am comatose, incompetent or otherwise mentally or physically incapable of communication, I designate _____ to make a decision on my behalf as to whether life prolonging procedures shall be withheld or withdrawn. I wish to be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain.

#2: If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal. I understand the full impact of this declaration, and I am emotionally and mentally competent to make this declaration.

(Signed) _____

The declarant is known to me, and I believe him or her to be of sound mind.

_____
(Witness)

_____
(Witness)