PATIENT SELF DETERMINATION QUESTIONNAIRE

You cannot remove all uncertainty about your future healthcare needs, but by having an advance directive, you can have the peace of mind that comes from making your wishes known in advance.

veriMED Health Group understands the importance of Advance Directives and encourages all patients to consider these to define the wishes so medical care can be provided in an appropriate and timely manner. In order to ensure this, and in accordance with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, **veriMED Health Group** uses this questionnaire to document in your medical records whether or not you have executed an Advance Directive.

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

☐ I have made such a declaration

☐ I have NOT made such a declaration

Health Care Surrogate

☐ I have designated a Health Care Surrogate

☐ I have NOT designated a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney

☐ I have NOT appointed a Durable Power for Health Care decisions

I have been provided information regarding the **PATIENT SELF DETERMINATION ACT**:

____

Full Name (Print)   Date of Birth   Social Security Number

Signature: ____ Date: __________________

Patient or Patient Representative

Relationship of Patient Representative (if applicable):_______________________________________

I have been provided with information regarding the **PATIENT SELF DETERMINATION ACT**, but decline to answer the above questions.

Signature of Patient or Patient Representative: ________________________________ Date: __________

Relationship of Patient Representative (if applicable):_______________________________________