FAMILY MEDICAL GROUP, P.A.
LIVING WILL (ADVANCE DIRECTIVE)
ACKNOWLEDGEMENT

DIRECTIONS: ***The purpose of this acknowledgment is to assure us that all of our patients are aware of the opportunity to sign an advance directive, which provides family members and the medical provider with knowledge of the patient's desire for continued life support measures if it becomes necessary. We ask that you sign the form which certifies that we have provided this information to you. Living Will forms may be obtained from your attorney, your local hospital or on the internet. If you currently have a living will, we would like a copy for our files. Thank you for your assistance.***

PATIENT NAME:_____
Last *First* *Middle*

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

PLEASE READ THE FOLLOWING FOUR STATEMENTS AND INITIAL EACH STATEMENT AFTER READING.

INITIAL	**STATEMENT**
1. _____	**1. I have been informed about my rights to accept or refuse medical treatment.**
2. _____	**2. I have been informed of my rights to formulate Advance Directives (Living Will).**
3. _____	**3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.**
4. _____	**4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.**

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

_____ **I HAVE executed an Advance Directive.**

_____ **I HAVE NOT executed an Advance Directive.**

Signed: _____ **Date:**_____

Witness: _____ **Date:**_____