Date_____

Advanced Health Care Directive

As your physician, I am required to ask any patient over the age of 18 if they have an existing Advanced Health Care Directive so that my I or my staff can incorporate the information into your medical records. You are not required to give us this information, but we are required to ask. Please complete below.

Patient Name_____ Soc Sec #_____

Signature _____ Date_____

1. I decline to answer these questions. □Yes □No
2. Do you have an advanced health care directive? □Yes □No
3. If Yes, please indicate which type:
   - #1 □ Durable Power of Attorney for Healthcare
   - #2 □California Natural Death Act
   - #3 □Living Health Care Will
   - #4 □Other:_____
4. Will you bring us a copy of your Directive? □Yes □No

Internal Office Use Only

Type of Directive Received:_____ Date Received:_____

Insurance Member Eligibility Waiver

Verification of your insurance (e.g. HMO, PPO, EPO, POS, etc) coverage for health care benefits cannot be made at this time. Services will be provided to you during this visit. However, in the event your coverage is NOT effective, you will be held responsible for all payments.

Patient Name_____ SS#_____

Subscriber Name_____ SS#_____

Address_____

Subscriber Phone (Day)_____ (Evening)_____

Medicare #_____ Date of Birth_____

Subscriber's Employer_____ Phone_____

Patient Signature_____

General Consent

I hereby consent and request diagnostic procedures (e.g. Xrays, blood tests, medical treatment) and treatment deemed advisable by the professional staff of this practice. I acknowledge that I have read this consent form and understand its contents. I have had an opportunity to discuss it, and any questions I had have been answered to my complete satisfaction.

Name_____ Signature_____

Parent/Legal Guard. Signature_____ Date_____

***** TWO-SIDED FORM (Complete Other Side)*****