SWOPE HEALTH SERVICES℠

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name: First Name: Middle Initial:	Social Security Number:	Birth Date:	Sex: ☐M ☐ F
Street Address:	City State, Zip:		County:
Mailing Address: ☐Same as above		Leave a message: ☐ Home Phone Number ☐ Cell Phone Number	
Email Address:	Home Phone Number:	Cell Phone Number:	Work Phone Number:
Marital Status: ☐Divorce ☐Married ☐Single ☐Separated ☐Widow	Preferred Pharmacy: «pharmacyName»	Homeless Status: ☐ Transitional ☐Doubling Up ☐ Homeless Shelter ☐ Other ☐Homeless ☐Seasonal ☐Migrant	

<u>Race</u>*:* ☐Asian ☐ American Indian/Alaskan Native ☐Black or African American ☐White ☐ Native Hawaiian ☐Pacific Islander ☐Unreported/Refused to Report

<u>Primary Language:</u> ______________________________

<u>Translator</u>: ☐Yes ☐No

<u>Ethnicity</u> *(choose only one):* ☐Hispanic/Latino ☐Not Hispanic ☐Refused to report

<u>Veteran Status</u> (*choose only one):* ☐Yes ☐No

Employer Name :	Employer Status: ☐Full Time ☐Part Time	Student: ☐Yes ☐No	Student Status: ☐Full Time ☐Part Time

Primary Care Provider (PCP) Name:

Does the patient have any problems with: ☐Vision ☐Hearing ☐Reading ☐Speaking
Explain:

Parent/Guardian <u>OR</u> Responsible Party Name:	Address: ☐Same as above	Phone Number: ( )
Parent/Guardian <u>OR</u> Responsible Party SSN:	Birth Date:	Relationship:

Housing (Check One): ☐Own ☐Rent ☐Public Assisted ☐Friend Other:______________________________

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the Patient Service Representative)

Person responsible for bill:	Birth date:	Address (if different):	Primary Phone Number: ( )
Occupation:	Employer:		Employer Phone Number:

Patients relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Step Child ☐Other

Primary Medical Insurance:	☐Medicare	☐Medicaid	☐Blue Cross Blue Shield	☐Other:
Subscriber's Name:	Birth Date:	Policy #:	Group #:	Co-Payment: $
Name of Secondary Medical Insurance (if applicable):	Subscriber's Name:	Birth Date:	Policy #: Group #:	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Primary Phone Number

Signature: Date:

«LastName», «FirstName» «MiddleInitial»

GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT
UPON REGISTRATION AND FINANCIAL RESPONSIBILITY

I hereby certify that I have not knowingly withheld any information or income or other financial resources and the amounts I have disclosed are true and correct to the best of my knowledge.

The undersigned patient and/or responsible person or relative having registered at Swope Health services for the purposes of obtaining health services, do hereby, voluntarily consent to such diagnostic and treatment services, as might be provided by or at the direction of a physician, dentist, other health care professional or other qualified member of the staff of the Swope Health Services to me according to his/her judgment.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Center.

I recognize that I will be asked to sign a specific consent for surgical and other special procedures including general and/or extensive local anesthesia.

I am aware that health services are not based on an exact science, and I acknowledge that no guarantees have been made to me as to the results of any treatment services,

I hereby authorize Swope Health Services to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience any specimen or tissue taken from my body during my treatment.

I hereby authorize payment of health insurance benefits recorded on the registration form to be paid directly to Swope Health Services for services provided.

I hereby authorize the Swope Health Services to furnish such information from my medical record pertaining to any and all treatment as requested by either health insurance plans or companies, if applicable to my case.

This form has been fully explained to me, and I certify that I understand its contents. **This file is to be updated in thirty days or one year which ever applies.**

I understand the charges for which I am responsible will reflect the balance due after credit for all appropriate discounts and all collections received by Swope Health Services from health insurance benefits for the above named individuals.

❑Medicare ❑Medicaid ❑Managed Care Plans ❑Mental Health ❑Homeless ❑Other (Specify) ___________________________

I agree to pay these charges on the day that the services are provided, within 10 days of receipt of the statement from Swope Health Services or by some other payment arrangement agreed to by Swope Health Services Patient Relations Office, telephone 816-923-5800

*** Knowingly concealing, failing to disclose, or providing false information with the intent to receive benefits that you are not entitled may result in prosecution, disbarment from Medicaid, Medicare and any other Government funded programs**

____ ________________________
Patient/Parent/Legal Guardian Signature **Date**

____ ________________________
Witness **Date**

I, the patient wish to authorize release of information about any claim upon its request to another organization which provides health insurance for me, or my State Medical assistance agency and/or to the Department of Mental Health.

____ ________________________
Patient/Parent/Legal Guardian Date

CONFIRMATION OF RECEIVING PATIENT BILL OF RIGHTS

I have received a brochure about the services offered at Swope Health Services. Inside of which is a copy of Swope Health Services "Patient Bill of Rights." After reading this document, I have had a chance to ask questions and I believe I understand what the Patient Bill of Rights means, what I might expect from this health care facility and what is expected of me and my family member(s) as registered patients here.

____ ________________ ________________
Patient/Parent/Legal Guardian Signature Date Interviewer Initial

SELF-DECLARATION OF INCOME FORM **Guarantor's account# _________________________**

I, ____ certify that my current annual household income is $__________ and my family size is _____________. I declare that all of my dependents are 18 years old and younger or disabled. I understand that this self-declaration is good for 30 days only. To receive a discount on services for a 12-month period, I will need to provide proof of my income by____________._____________________________________

❑ I decline to participate in the sliding fee discount program.

Guarantor Signature____ **Date**_____________________

Witnessed By ____ **Date**_____________________

SWOPE HEALTH SERVICES℠

Notice of Privacy Practices

Name:

DOB:

SHS is committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgment of Receipt

I, ___________________________________, hereby acknowledge that I have received a Copy of the Notice of Privacy Practices.

____

Patient's Signature   Date

____

Signature of Parent or Patient's Representative (if applicable)

____

Description of Legal Authority to act on Behalf of Patient

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Sliding Fee Discount Eligibility Form

It may be necessary to ask some personal questions in order to determine eligibility for a discount on medical, dental or pharmaceutical charges. This information is private and confidential and will be kept on file at Swope Health Services. Income verification is determined once a year and requires proof of income and Proof of address documents to be return to Swope Health Services. (Family size and annual gross household income will be used to calculate discount and level of payment.)

List other Household Members 19 years of age and older that live with you.

	Name	DOB	Relationship
1			
2			
3			
4			
5			
6			

List other Household Members 18 years of age and younger or disabled that live with you.

	Name	DOB	Relationship
1			
2			
3			
4			
5			
6			
7			
8			
9			

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Do you have any wage income from any of the following household members:

	Sources	Hourly Rate	Hours Worked	Bi-weekly Income	Hours worked
	You				
	Your Spouse or Significant Other				
	Other persons (Please List)				

Do you have any income from any of the following sources and if so, how much per month?

	Sources	You	Your Spouse	Your Children	Other Persons	Total Sources
	Social Security					
	Public Assistance					
	Retirement Pension					
	Rental Income					
	Interest Income					
	Child Support - Alimony					
	Other (Specify)					

The sliding fee discount program has been explained to me, and I acknowledge that deliberately providing false or incomplete information in regard to determining the level of sliding fee scale discount can disqualify me or family members from being eligible for this program.

Guarantor Signature____ **Date**_____________________

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Sliding Fee Discount- Revised Oct 2016

If you are not insured, fees for clinic services are based on your income and family size and may be reduced if you live on a limited income according to state and federal guidelines. To qualify for discounts, you must present the following information as applicable when you register:

Acceptable Documentation for Proof of Income (please provide proof for all family/household income):

- Current Paycheck stub.
- A letter on company letterhead. Please include the following information: hourly rate, gross pay and the pay period.

  If your employer does not have company letterhead, we will accept a notarized letter from your Employer.

  Please include the following information: hourly rate, gross pay and the pay period.
- Current Unemployment Determination Letter.
- Social Security, pension, trust, SSI Disability award letter, food stamp summary or child support check.
- Current financial aid, Pell Grants, scholarship papers.
- Current tax information.
- W2 Forms (adjusted gross income).
- For elderly parents living with adult children or adult grandchildren, include income if adult children or adult grandchildren claim parents as dependents on their tax return. Otherwise, parents should be considered as independent for the purposes of income and so do not count their adult children's income.
- Non-cash items such as food stamps are not included in the income

Acceptable Documentation for Proof of Address:

- Current utility (electric, gas or telephone) bills.
- A current piece of mail addressed to you (within 30 days).
- Current pay check stub with your current mailing address located on the check stub.
- Any government information that was mailed to you (Social Security, pension, trust, SSI Disability Award letter, food stamp summary or child support check.
- Lease or mortgage agreement.

PLEASE ENSURE YOU RETURN ALL THE INFORMATION AT THE SAME TIME

I understand if I do not provide the above information within thirty (30) days from today, I will be fully responsible for all services rendered and these services will be billed at the full price until information is returned.

You may return requested information Monday through Friday from 8:00am to 4:30pm.

Acceptable Documentation for Identification

- Driver's License (Includes Expired)
- Matricula Consular/ Consular Identification Card http://www.migrationpolicy.org/article/consular-id-cards-mexico-and-beyond
- Passport (Includes Expired)
- School/College Identification Card
- Guardianship Documentation
- Social Security Card
- Birth Certificate
- An Individual Taxpayer Identification Number (ITIN)- This is a tax processing number issued by the Internal Revenue Service. It is a nine-digit number that always begins with the number 9 and has a range of 70-88 in the fourth and fifth digit. Effective **April 12, 2011**, the range was extended to include 900-70-0000 through 999-88-9999, 900-90-0000 through 999-92-9999 and 900-94-0000 through 999-99-9999. IRS issues ITINs to individuals who are required to have a U.S. taxpayer identification number but who do not have, and are not eligible to obtain a Social Security Number (SSN) from the Social Security Administration (SSA).

Who does SHS define as "Family/Household"?

- Husband, Wife and Dependent Children (any age, related biologically or adopted)
- Significant Other
- Unmarried Partners
- Mother, Father if included on the tax return
- Grandparents if included on the tax return
- Grandchildren if included on the tax return
- All members included on the tax return

STEPS TO FILE AN UNEMPLOYMENT DETERMINATION CLAIM

1. Call 816/889-3101 Missouri or 913/596-3500 Kansas
2. Press 1 to file claim
3. Enter social security number
4. Press 1
5. Select your Pin Number (This is a number you make up)
6. Press 1 for YES and 9 for NO
7. Press 1 to File by Phone
8. Follow Instructions for Address and Zip Code
9. Remain on the phone until you speak with a representative (Do not hang up)
10. Tell the representative you need the form letter showing you are either the insured or uninsured worker

The representative will mail you a Benefits Determination Letter

Patient Authorization and Consent (Opt-In) Form

Swope Health Services ("SHS") participates in the Missouri Health Connection (MHC) health information exchange network. MHC's secure, electronic network allows doctors and other caregivers to quickly electronically share a patient's health records. Only authorized health care providers/organizations and professionals involved in a patient's treatment, care, quality improvement and management or payment of a patient's healthcare are allowed access to a patient's records. A full list of health care providers that are members of MHC can be viewed at www.missourihealthconnection.org. Medical record information is protected under federal and state privacy laws; access, use and disclosure of medical records will comply with the laws.

By signing this form, I understand, agree and consent to the following (If you are a patient's legal representative or guardian, "me," "my" or "I" refer to the Patient):

1. This form is for patients who want to share their health information using the MHC health information network. By signing this form, I agree to allow my healthcare providers to electronically share my health records.
2. MHC has penalties for anyone sharing my data in the wrong way.
3. My health care providers that are members of MHC may copy or include my health data in their own medical records when caring for me. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them.
4. MHC will keep track of who views my health records to make sure they are secure. I can ask my doctor or MHC for a list of who has looked at my records. If I suspect or learn that my data was shared or accessed in the wrong way, I may contact MHC at: 1-866-350-4778; info@MissouriHealthConnection.org or PMB 270, 2000 E. Broadway, Columbia, MO 65201-6091.
5. I have received information about sharing my health records through the MHC Network.
6. I understand and agree that MHC and healthcare providers participating in the MHC Network:
    - Will share my health data with providers who are treating me.
    - Will be able to see all of my health records from both before and after today's date.
    - May use or share my health data, but only as allowed by federal and state laws. This is the same as for my health records in paper form.
    - May share all of my health records with providers who are treating me; this includes but is not limited to: illnesses or injuries, test results, medicines I am taking or have taken, and sensitive data including but not limited to:
        - Alcohol or substance abuse problems
        - Genetic (inherited) diseases or tests
        - HIV/AIDS
        - Mental health and developmental disabilities
    - Family planning information (including abortions)
    - Sexually transmitted diseases
    - Head and spinal cord injuries
7. Using my health information for marketing or advertising purposes, or to determine insurance or employment eligibility, is strictly prohibited.
8. My consent will remain in effect until the day I cancel my account by "Opting Out." I can cancel my consent or opt-out of sharing my health records with MHC at any time.
9. I may ask for a copy of this form after I sign it and acknowledge that it can take up to 10 business days to process this form.

By signing this form, I give all MHC participating providers the right to share all of my health records, including sensitive data, through MHC's Network for purposes of providing care to me. MHC has the right to contact me do identity verification.

Print Full Name (First, Middle, Last, (Maiden)): ____
Date of Birth (Day, Month, Year): ____
Address (Street, City, State, Zip Code): ____
Phone (xxx-xxx-xxxx): ______________________________Email:___________________________________
Printed Name of Legal Representative:____
Relationship of Legal Representative *(If I am the parent or guardian of a child, I can consent on behalf of the child only until he or she turns 18. At that time, the child will be automatically opted out unless he or she chooses to join the MHC network.)*:
____

My or My Legal Representative's Signature*____
Date of Signature: ____

MHC Participating Health Care Provider Member Organization Name:__________________________________
Representative Name (print):____
Representative Title:_____________________________________**Date:**________________ **Phone:** ____________________

Representative Signature: ____

SWOPE HEALTH SERVICES

3801 Blue Parkway
Kansas City, MO. 64130
(816)923-5800 FAX: (816) 922-7682

Authorization for Release of Protected Health Information

To be completed by the patient or the patient's authorized representative:

Patient's Name ___________________________________*Date of Birth:* ____________
Street Address
City *State* *Zip Code*
____
Telephone *Fax*

I hereby authorize:

☐ Swope Health Services, **OR**
☐ ____
Name of Physician or Provider
____
Street Address
____
City *State* *Zip Code*
____
Telephone *Fax*

To release my confidential health information, as described below, to: ☐ me

☐ Swope Health Services, **or**
☐ ____
Name
____
Organization Name
____
Street Address
____
City *State* *Zip Code*
____
Telephone *Fax*

☐ copies by mail ☐ inspection
☐ copies by fax ☐ other: ____________________
☐ copies to be picked-up

For the following purpose(s):

- *If for marketing purposes, indicate whether the marketing involves direct or indirect payment to Swope Health Services.*
- *If requested by the patient, a statement "at the request of patient" is sufficient.*

____
____
____

My authorization is for the use and disclosure of the following records:

___ Statements of charges and payments
___ Diagnosis/treatment of medical illness and records of medical examinations
___ Mental health records
___ Dental records
___ Evaluation and treatment records related to alcohol and/or drug abuse.
___ X-rays and other images
___ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
___ Other: ____
___ All of the above

My authorization pertains to information generated on the following date(s) or in the following time period:

____
___

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Swope Health Services may not condition my treatment on my provision of this authorization.
- This authorization is valid for a thirty (30) day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as valid as the original.
- Swope Health Services, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of Swope Health Services.

This authorization will expire on: _____________________________

____
Patient's Signature Date

____
Signature of Parent or Personal Representative Date

____
Name of Parent or Personal Representative (please print)

____
Description of Legal Authority to Act on Behalf of Patient

____
Witness Signature Date

SWOPE HEALTH SERVICES
3801 Blue Parkway
Kansas City, MO. 64130-2807
(816) 923-5800

Name: «LastName», «FirstName» «MiddleInitial»
DOB: «DOB»
Account Number: «PatientAcccountNumer»

To Our Patients:

In accordance with the Patient Self – Determination Act of 1990, Swope Health Services wants you to be informed of your rights and options as follows:

1. **Kansas and Missouri have authorized Living Wills (now referred to as Health Care Treatment Directives) by which patients can express their own treatment decisions; and Durable Power of Attorney for Health Care, by which patient can appoint a surrogate or agent to make health care treatment decisions for them. The term for these forms together is Advance Directive.**

2. **The attached information includes the forms and a general description of issues involved in an Advance Directive. If you wish to issue an Advance Directive, please contact your personal attorney or Legal Aid at 816-474-6750. Kansas residents for Legal Aid contact 913-621-0200.**

3. **If you do formulate an Advance Directive, bring it with you to your next appointment and ask your physician to enter it into your medical record; or mail it to your physician with the instruction to have it placed in your medical record.**

Health Care Treatment Directive

I «FirstName» «MiddleInitial» «LastName» make this Health Care Treatment Directive to exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions **when I lack the capacity to make or communicate my decisions** and there is no realistic hope that I will regain such capacity.

If my physician believes that a certain life prolonging procedure or other health care treatment may provide me with comfort, relieve pain or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. However, if such treatment proves to be ineffective, I direct treatment be withdrawn even if so doing may shorten my life.

I direct I be given health care treatment to relieve pain or to provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit – forming.

I direct all life prolonging procedures be withheld or withdrawn when there is no hope of significant recovery, and I have:

- a terminal condition; or
- a condition, disease or injury without reasonable expectation that I will regain an acceptable quality of life; or
- substantial brain damage or brain disease which cannot be significantly reversed.

1.) When any of the above conditions exist, **I DO NOT WANT** the life prolonging procedures which I have initialed below. (You should assume any treatments not initialed may be administered to you.)
   - Surgery…………………………………………………………………._________ initials
   - Heart-lung resuscitation (CPR)……………………………………._________ initials
   - Antibiotics ……………………………………………………………_________ initials
   - Dialysis ………………………………………………………………_________ initials
   - Mechanical ventilator (respirator) …………………………………._________ initials
   - Tube feedings (food and water delivered through a tube in the vein, nose, or stomach ………………………………………………………………………. _________ initials
   - Other ____...................... _________ initials

2.) I make other instructions as follows: (**You may describe what a minimally acceptable quality of life is for you.)**

____

____

If you do not wish to name an agent as referred to on the reverse side, initial here _____________, write "None" in the space provided for agent's name, sign and have witnessed and/or notarized.

Discuss this document and your ideas about quality of life with your agent, physician(s), family members, friends and clergy and provide them a signed copy (or photocopy thereof). You may revoke or change this document. Periodic review is recommended. If there are no changes after each review, initial and date in the margin.

(This document is provided as service by the Kansas City Metropolitan Bar Association and its foundation, the Metropolitan Medical Society of Greater Kansas City, Midwest Bioethics Center and the Missouri Lawyer Trust Account Foundation).

ADVANCE DIRECTIVES

A MEDICAL ISSUE: A PERSONAL CONCERN

The American public has become increasingly aware of medicine's new-found capabilities to sustain bodily functions long after many believe a quality of life acceptable to the patient has ended - - even when patients and families may not wish further treatment.

A SOLUTION: ADVANCE DIRECTIVES

An Advance Directive is a document which allows you to communicate your health care treatment preferences when decision making capacity is lost. A recent U.S. Supreme Court decision (Cruzan) clearly indicates that all people have a constitutional right of liberty to refuse any medical treatment, including life prolonging procedures. Further the court's decision affirms the right to name an agent to be a surrogate decision-maker for health care issues in the event you lose decision-making capacity.

The Midwest Bioethics Center, the Kansas City Metropolitan Bar Association, and the Metropolitan Medical Society of Greater Kansas City have formed a partnership (the Advance Directives Community Project) to educate people about their rights regarding health care decision-making. Further, the project has developed an Advance Directive which assists you in thinking about your options and documenting your wishes. This Advance Directive has two parts:(1) a Health Care Treatment Directive, and (2) a Durable Power of Attorney for Health Care Decisions.

THE HEALTH CARE TREATMENT DIERECTIVE (LIVING WILL)

This Health Care Treatment Directive is a signed, dated and witnesses document that allows you to state, in advance, your wishes regarding the use of life-prolonging procedures. It is similar to a Living Will, with which people are familiar; however, it is far more comprehensive than most Living Wills. Further, the Health Care Treatment Directive is not restricted to use only when you are terminally ill. Like the Living Will, the Health Care Directive has no effect until you can no longer make or communicate decisions for yourself.

THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

The Durable Power of Attorney for Health Care Decisions provides a way for you to appoint an agent to make health care decisions which you have not already covered in your Health Care Treatment Directive. This document goes into effect, WHEN, AND ONLY WHEN, you lack capacity to make or to communicate decisions for yourself.

THE BENEFIT OF COMMUNICATION

Your right to enact an Advance Directive has been legally supported by the U.S. Supreme Court. However, the greatest benefit of your Advance Directive is its power as a communication tool. Ask your doctor or lawyer to discuss the Advance Directive with you. Also, make your wishes about health care known to family, friends, and clergy.

COMMONLY ASKED QUESTIONS ABOUT ADVANCE DIRECTIVES

"Advance Directive" is a general term used in this brochure to apply to both the Health Care Treatment and the Durable Power of Attorney for Health Care. It is a term also frequently used to refer to Living Wills.

1. **How is a Health Care Treatment Directive and Durable Power of Attorney for Health Care Decisions different from a Living Will?**

   A Health Care Treatment Directive is similar to a Living Will, in that it is a signed, dated, and witnessed document that allows you to state, in advance, your wishes regarding the use of life-prolonging procedures. The Health Care Treatment Directive does not focus exclusively on refusing treatment. You may use your Health Care Treatment Directive to state when to continue, or when to discontinue, life-prolonging treatments. It is much more comprehensive than most Living Wills, in that it is not restricted to use only when you are terminally ill.

   The Durable Power of Attorney for Health Care Decisions allows you to name an agent to make treatment decisions for you about issues you have not adequately covered in your Health Care Treatment Directive.

2. **Why is it useful to have both a Health Care Treatment Directive and a Durable Power of Attorney for Health Care Decisions?**

   Due to the complexity of illnesses, circumstances and treatment options, situations may arise when it is not clear from your Health Care Directive what your decision in a particular situation would be. To provide for that event, you may wish to name a person you trust to make decisions for you.

3. **How is the Durable Power of Attorney for Health Care Decisions different from a regular power of attorney?**

   Generally powers of attorney refer to business and financial matters. A Durable Power of Attorney for Health Care more clearly allows you to name an agent to make heath care treatment decisions and does not cover business or financial matters. Many people choose to name separate agents for business and health care decisions and use separate documents to do so. THIS DOCUMENT ADDRESSES HEALTH CARE MATTERS ONLY.

4. **Whom should I name as my agent?**

   It is important that you name an agent who knows your goals and values and who you trust to act in accordance with your wishes. You may name a family member, but it is not necessary to do so. You might choose your spouse, an adult child, or a close friend. Be sure to talk with your agent about your wishes in detail, and confirm that he or she agrees to act on your behalf.

5. **If I have already enacted a Living Will, do I need a Health Treatment Directive and Durable Power of Attorney for Health Care Decisions?**

   The Living Will you have may not be as comprehensive as this Health Care Treatment Directive. Furthermore, your Living Will probably does not allow you to name an agent. There is clearly a benefit to being as specific as possible when making an Advance Directive. If you decide to enact the more comprehensive Health Care Treatment Directive and Durable Power of Attorney for Health Care Decisions, be certain you notify person to whom you have distributed your Living Will that is revoked, and provide them with a copy of your new Health Care Treatment Directive.

6. **If I completed the Living Will Declaration and Optional Additional Instructions, as previously distributed by Midwest Bioethics Center and the Kansas City Metropolitan Bar Association, do I need to revoke it and enact this new Health Care Treatment Directive and Durable Power of Attorney for Health Care?**

   The previous document is as comprehensive as the first part of this Advance Directive (i.e., the Health Care Treatment Directive) and would suffice, unless you wish to name an agent. If you wish to name an agent, you should revoke the previous document, notify persons who have copies of it, and send them a copy of your newly – enacted Health Care Treatment Directive and Durable Power of Attorney.

7. **Do I need an attorney to enact a Health Care Treatment Directive or Durable Power of Attorney for Health Care Decisions?**

   No. However, you may wish to communicate with an attorney.

8. **Does my Advance Directive have to be notarized?**

   Notarization is required in some states (e.g., Missouri, but not Kansas) to enact a Durable Power of Attorney for Health Care Decisions and is recommended for anyone enacting an Advance Directive.

9. **How do I give notice that I have enacted a Health Care Treatment Directive and Durable Power of Attorney for Health Care Decisions?**

   It is your responsibility to notify and provide copies of your Health Care Treatment Directive and Durable Power of Attorney for Health Care Decisions to the agent(s) named in your Durable Power of Attorney for Health Care Decisions and other appropriate individuals, i.e., physicians, family, friends, and clergy. Discuss the details of your Advance Directive with these individuals, and ask your physician to make it a part of your permanent medical record.

10. **When does my Health Care Treatment Directive and Durable Power of Attorney for Health Care Decisions go into effect?**

    You're Health Care Treatment Directive and Durable Power of Attorney for Health Care Decisions goes into effect WHEN AND ONLY WHEN, you are no longer able to make or communicate your decisions. So long as you can make decisions, it is both your right and responsibility to make your own decisions.

11. **How long will my Advance Directive be effective; may I change or revoke it?**

    Your Advance Directive is effective until the time of your death, or unless you revoke it. It is recommended that you review your Advance Directive periodically. Each time that you do this, re-date and initial it in the margins of your document. This will serve as a powerful indicator that your directions have been well thought out.

12. **Will my Health Care Treatment Directive and Durable Power of Attorney for Health Care Decisions be honored if I am in another state?**

    The U.S. Supreme Court recently states that all adults have the right to refuse health care treatment. If properly enacted, you should expect your Advance Directive to be honored in any state.

13. **Must my physician, agent and institution carry out my wishes expressed in my Health Care Treatment Directive?**

    Yes. Health care providers and your agent are obligated to honor your wishes, as expressed in your Advance Directive, so long as directions you have made comply with state law. Any provider who will not honor your Health Care Treatment Directive or decisions made by your agent is obligated to assist in arranging your transfer to a provider who will honor your Advance Directive.

14. **Can my Health Care Treatment Directive or decision made by my agent be overridden by my family members?**

    No. If you have designated an agent, only he/she has the legal authority to make health care decisions for you. However, your agent may wish to obtain additional information from your family to assist him/her in making decisions.

15. **Will my Health Care Treatment Directive be honored in an emergency situation?**

    The Health Care Treatment Directive clearly states that if it is uncertain whether or not a treatment will "lead to a significant recovery", it should be tried for a reasonable period of time. Since in an emergency situation it may be impossible for the health care providers to make this judgment, you should assume that treatment would be tried until it proves to be futile. If treatment does not lead to a significant recovery, you should expect that your Advance Directive would be honored, and treatment
    which has proven to be futile should be withdrawn.

16. **What if I do not want to be resuscitated (CPR) under any circumstances?**

    You may write that in your Health Care Treatment Directive and, certainly should inform your agent. However, if you do not want to be resuscitated only because of the fear of being "trapped" on life support, this concern has been addressed in the Health Care Treatment Directive. The Health Care Treatment Directive clearly states that if it is uncertain whether or not a treatment will "lead to a significant recover", it should be tried for a reasonable period of time. In the event you are certain you do not want CPR under ANY circumstances, contact your local emergency medical service provider to inquire about whether there is a way they can honor your request.

17. **How can I describe what a "minimally acceptable quality of life" means to me?**

    When enacting the Health Care Treatment Directive, it is important to describe what you personally mean by "minimally acceptable quality of life". There is no single "right" answer to this question. Your description should attempt to express your personal goals and values.

18. **May I request that artificially-administered food and water (tube-feedings) be withdrawn?**

    Yes. The constitutional right of liberty supports refusals of any medical treatment, including artificial feeding. Accordingly, a clear request in your Health Care Treatment Directive should be honored.

19. **May I make a provision for donating organs or tissues in my Advance Directive?**

    Yes. You may wish to make such a statement in your Health Care Treatment Directive. Persons wishing to make such statements should enact the Uniform Anatomical Donation Statement on the back of their driver's license.

20. **Will my Advance Directive affect my life or health insurance?**

    No. Your signature on the Advance Directive will not invalidate or alter insurance policies, nor affect your ability to obtain life or health insurance.

<u>SOURCE</u>

Midwest Bioethics Center, Suite 106, 410 Archibald, Kansas City, Missouri 64111, (816) 756-1735

SWOPE HEALTH SERVICES℠

Patient Rights

At Swope Health Services, we are committed to providing you quality medical and behavioral health services. As a patient, you have certain rights. Understanding those rights will help you get the best possible care. You have the right:

1. To receive compassionate and respectful care regardless of age, sex, race, national origin, religion, disability, sexual orientation, or communicable disease.
2. To be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.
3. To be well informed from their doctor/designee about the diagnosis, treatment, and chances for recovery in understandable terms. This information should include the specific treatment, medical risks, benefits, side effects.
4. To know the names, roles, and credentials of people providing medical treatment.
5. To exclude any and all family members from participating in health care decisions (in accordance with applicable laws).
6. To receive sufficient information to help the patient or client make decisions involving their health care.
7. To refuse recommended treatment to the extent permitted by law, and to be told what will happen medically if that is the patient or client's choice.
8. To medical privacy and confidentiality of all records pertaining to treatment, except as required by law or third party payment.
9. To have their medical record read only by individuals directly involved in or supervising their treatment, monitoring the quality of the treatment provided, or authorized by law or regulation.
10. To have access to information contained in the patient or client's medical record, within the limit of the law and facility policy.
11. To amend the medical record if there is information the patient or client believes to be incorrect.
12. To give or withhold informed consent to take part in research, investigation, or clinical trials. Any human experimentation affecting care or treatment will be performed only with appropriate informed consent.
13. To give or withhold informed consent to produce or use recordings, films, or other images of the patient for purposes other than his/her care.
14. To expect the facility to respond reasonably to a patient or client's request for medical services. The facility must serve the patient/client in a way that reflects the urgency of the case. In extreme cases, the patient or client may be transferred to another medical facility. Except in an emergency, each patient or client has the right to receive as much information as possible about the need for- and alternatives to- a transfer. Patients and clients cannot be relocated until after the other facility has accepted the transfer.
15. To formulate an Advance Directive, express his/her choices about future care and appoint someone to make decisions for him/her if unable to do so.
16. To access protective services or information regarding protective services. If patients or clients would like additional information about obtaining help for child abuse, elder abuse, or domestic violence, they should contact the Patient Advocate.

(Over)

Patient Rights (Continued)

17. To know which agencies survey or accredit our organization and the department(s) within which she/he may be a patient or client.
18. To receive information about the relationships between the Health Center and other health care and educational facilities involved in providing care, to find out if any professional, financial, control, or ownership relationships exist among treating providers at any of the facilities involved.
19. To express verbally or by letter, any complaints or recommendations concerning services. Patients/Clients may communicate a complaint or grievance in writing or by calling the manager of the clinic or program involved; or, if not satisfied with the outcome after working with the manager, may call or write the Swope Health Services Risk Manager.

    Patients/clients may contact Joint Commission directly by accessing the Joint Commission website www.complaint@jointcommission.org or by calling 1-800-994-6610.

    Patients using our Behavioral Health Services may contact the Behavioral Health department directly, or file a formal grievance with the Department of Mental Health, 1706 E. Elm Street, PO Box 687, Jefferson City, MO 65102. Phone: (573) 751-4122.

Patient Responsibilities

The care you receive is partially dependent upon your acting in a cooperative manner with your health care providers, including communication openly and honestly, following treatment plans, and respecting the facility standards of conduct. As a patient at Swope Health Services, you are responsible for:

1. Following all facility rules.
2. Providing accurate and complete information about current symptoms, past illnesses, hospitalizations, medications, advance directives, and any other matters related to care.
3. Following instructions that the patient/client and their health care provider have agreed upon.
4. Asking questions about his/her care that he/she may not understand or have questions about, including risks of procedures, outcomes, and costs of treatment.
5. Making informed decisions about care and treatment.
6. Knowing what medications or drugs he/she is taking, why he/she is taking them, and the proper way to take them according to their provider's instructions.
7. Keeping scheduled appointments, arriving on time for scheduled appointments, and for calling as soon as possible to cancel when patient cannot keep a scheduled appointment.
8. Advising SHS of any changes in the following:
    a. Address
    b. Phone Number
    c. Income
    d. Family Size
    e. Insurance Information
9. Respecting and considering other people, associates, the property of others, and property of Swope Health Services.
10. Attending and supervising patient's children while in the facility.
11. Paying bills and fees promptly.