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ADVANCE DIRECTIVE POLICY

AN ADVANCE DIRECTIVE IS A WRITTEN INSTRUCTION, SUCH AS A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTHCARE, RECOGNIZED UNDER STATE LAW, RELATING TO THE PROVISION OF HEALTHCARE WHEN THE INDIVIDUAL WHO HAS ISSUED THE DIRECTIVE IS INCAPACITATED.

THIS FACILITY RECOGNIZES THE PATIENT'S RIGHT TO HAVE ADVANCED DIRECTIVES AND A LIVING WILL ACCORDING TO THE FEDERAL AND STATE OF ARIZONA LAWS AND STATUTES. (REFER TO SECTION I.) FACILITY STAFF WILL IMPLEMENT AND COMPLY WITH PATIENT ADVANCE DIRECTIVES EXCEPT AS OTHERWISE EXPRESSLY PROVIDED IN THIS POLICY. THE ADVANCE DIRECTIVE POLICY WILL BE PROVIDED TO EACH PATIENT PRIOR TO ANY SURGICAL PROCEDURE.

THIS FACILITY ALSO RECOGNIZES THAT THE PURPOSE OF BEING AN AMBULATORY SURGERY CENTER IS TO PROVIDE ELECTIVE SURGICAL PROCEDURES TO ASA CLASS I, II AND STABLE CLASS III PATIENTS, MEANING THE FACILITY TREATS GENERALLY HEALTHY PATIENTS. IN ALL INSTANCES OF EMERGENCY OR LIFE THREATENING SITUATIONS, LIFE-SUSTAINING TREATMENT (INCLUDING RESUSCITATIVE SERVICES) WILL BE INSTITUTED FOR STABILIZING PURPOSES AND PATIENTS IMMEDIATELY TRANSFERRED TO A HIGHER LEVEL OF CARE.

SECTION I. STATE OF ARIZONA

IN THE STATE OF ARIZONA, ALL PATIENTS HAVE THE RIGHT TO PARTICIPATE IN THEIR OWN HEALTH CARE DECISIONS AND TO MAKE ADVANCE DIRECTIVES OR TO EXECUTE POWERS OF ATTORNEY THAT AUTHORIZE OTHERS TO MAKE DECISIONS ON THEIR BEHALF BASED ON THE PATIENT'S EXPRESSED WISHES WHEN THE PATIENT IS UNABLE TO MAKE DECISIONS OR UNABLE TO COMMUNICATE DECISIONS. THE FACILITY RESPECTS AND UPHOLDS THOSE RIGHTS AND WILL IMPLEMENT AND COMPLY WITH PATIENT ADVANCE DIRECTIVES EXCEPT AS OTHERWISE EXPRESSLY PROVIDED HEREIN. THE FACILITY HAS NO BLANKET POLICY OF REFUSAL TO COMPLY WITH ANY ADVANCE DIRECTIVE. HOWEVER, THE FACILITY'S COMPLIANCE WITH CERTAIN ELEMENTS OF AN ADVANCE DIRECTIVE IS SUBJECT TO THE LIMITATIONS DELINEATED BELOW.

CANDIDATES FOR PROCEDURES PERFORMED AT THIS FACILITY ARE REQUIRED TO BE ASA CLASS I, II, OR STABLE III, MEANING THE FACILITY TREATS GENERALLY HEALTHY PATIENTS, HAS LIMITED CAPABILITIES AND DOES NOT ROUTINELY PERFORM PROCEDURES OR SERVICES THAT CREATE THE LIKELIHOOD OF HAVING TO IMPLEMENT OR WITHDRAW LIFE-SUSTAINING TREATMENT OR SERVICES. ANY LIFE THREATENING SITUATION WITHIN THE FACILITY WOULD LIKELY BE DUE TO AN UNEXPECTED COMPLICATION, RATHER THAN THE CONDITION OF AN INDIVIDUAL PATIENT OR AN EXISTING CO-MORBIDITY. ACCORDINGLY, THIS FACILITY CANNOT IN GOOD CONSCIENCE IMPLEMENT AN ELEMENT OF ANY ADVANCE DIRECTIVE THAT REQUIRES THE WITHHOLDING OF EMERGENT RESUSCITATION OR OTHER LIFE-SUSTAINING SUPPORT. **IN ACCORDANCE WITH THE FACILITY'S RULES AND REGULATIONS AND 42 C.F.R. §416.41(B), ANY PATIENT THAT REQUIRES CARE FOR AN EMERGENCY MEDICAL CONDITION THAT IS BEYOND THE CAPABILITIES OF THE FACILITY WILL BE IMMEDIATELY TRANSFERRED TO A HOSPITAL, PURSUANT TO A TRANSFER AGREEMENT, OR TO ANOTHER LOCAL MEDICARE-PARTICIPATING HOSPITAL.**

ACCORDINGLY, IT SHALL BE THE POLICY OF THE FACILITY, FOR REASONS OF CONSCIENCE, TO REFUSE TO COMPLY WITH THE ELEMENTS OF A PATIENT'S ADVANCE DIRECTIVE THAT REQUIRE THE WITHHOLDING OF EMERGENT RESUSCITATION OR LIFE-SUSTAINING TREATMENT. THE FACILITY SHALL ALWAYS PROMPTLY AND IMMEDIATELY SO NOTIFY PATIENTS OF THE FACILITY'S UNWILLINGNESS, PURSUANT TO ARIZ. REV. STAT. §36-3205(C) (1). IN THE EVENT THE FACILITY REFUSES IMPLEMENTATION OF A PATIENT'S ADVANCE DIRECTIVE AS SET FORTH HEREIN, THE FACILITY WILL PROMPTLY TRANSFER THE PATIENT TO ANOTHER PROVIDER WHO IS WILLING TO ACT IN ACCORDANCE WITH THE DIRECTIVE. ARIZ. REV. STAT. §36-3205(C) (1). ADDITIONALLY AND PURSUANT TO ARIZ. REV. STAT. §36-3204(A), THE FACILITY MAY ELECT TO NOT COMPLY WITH HEALTH CARE DECISIONS MADE BY THE PATIENT'S SURROGATE IF THE FACILITY HAS TRANSFERRED RESPONSIBILITY TO ANOTHER PROVIDER WHO IS WILLING TO ACT IN ACCORDANCE WITH THE DIRECTIVE. A MEMBER OF THE MEDICAL STAFF MAY SIMILARLY DECLINE TO COMPLY WITH ELEMENTS OF A PATIENT'S ADVANCE DIRECTIVE FOR REASONS OF CONSCIENCE BY FOLLOWING THE SAME PROCEDURES AND PROCESSES DELINEATED HEREIN AND AS PERMITTED BY ARIZONA LAW.

THE RANGE OF MEDICAL CONDITIONS AND PROCEDURES AFFECTED BY THE FACILITY'S AFOREMENTIONED STATEMENT OF LIMITATIONS INCLUDES:

ALL PATIENTS REGARDLESS OF AGE, MEDICAL CONDITION, AND/OR SURGERY/PROCEDURE TO BE PERFORMED.

A PATIENT'S AGREEMENT WITH THIS FACILITY'S POLICY WILL NOT REVOKE OR INVALIDATE ANY CURRENT HEALTH CARE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY.

THIS FACILITY SHALL PROVIDE THE PATIENT, THE PATIENT'S REPRESENTATIVE OR SURROGATE WITH INFORMATION CONCERNING ITS POLICY ON ADVANCE DIRECTIVES, INCLUDING A DESCRIPTION OF APPLICABLE STATE HEALTH AND SAFETY LAWS AND, IF REQUESTED, OFFICIAL STATE ADVANCE DIRECTIVES FORMS PRIOR TO THE SURGICAL PROCEDURE.

IF THE PATIENT CHOOSES TO SEEK ALTERNATIVE CARE DUE TO THE FACILITY'S DOCUMENTED LIMITATIONS ON COMPLYING WITH CERTAIN ASPECTS OF ADVANCE DIRECTIVES/LIVING WILLS, THE FACILITY WILL PROVIDE THE APPROPRIATE REFERRAL FOR THE PATIENT.

EXCEPT AS OTHERWISE REQUIRED BY APPLICABLE LAW AND FACILITY POLICY, THE FACILITY WILL NOT ASSIST THE PATIENT IN THE DEVELOPMENT OF ADVANCE DIRECTIVES/LIVING WILL.

IF YOU DO NOT AGREE TO THIS POLICY, WE ARE PLEASED TO ASSIST YOU TO RESCHEDULE THE PROCEDURE.

PLEASE CHECK THE APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS. HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, A POWER OF ATTORNEY THAT AUTHORIZES SOMEONE TO MAKE HEALTH CARE DECISIONS FOR YOU?

YES, I HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY

COPY PROVIDED OR DIRECTIVE ON FILE HAS BEEN REVIEWED AND IS CORRECT

NO COPY PROVIDED AT THIS TIME

NO, I DO NOT HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY

I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES

IF YOU CHECKED THE FIRST BOX "YES" TO THE QUESTION ABOVE, PLEASE PROVIDE US A COPY OF THAT DOCUMENT SO THAT IT MAY BE MADE A PART OF YOUR MEDICAL RECORD.

Please visit the Arizona Attorney General's Website http://www.azsos.gov/adv_dir/ for forms or more information regarding Advance Directives.

BY SIGNING THIS DOCUMENT I ACKNOWLEDGE THAT I HAVE RECEIVED THIS INFORMATION BOTH VERBALLY AND IN WRITING PRIOR TO MY PROCEDURE AND HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED.

IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THAT INFORMATION.

BY: _____ DATE: _____
(PATIENT'S SIGNATURE)

RELATIONSHIP TO PATIENT: _____

IF CONSENT TO THE PROCEDURE IS PROVIDED BY ANYONE OTHER THAN THE PATIENT, THIS FORM MUST BE SIGNED BY THE PERSON PROVIDING THE CONSENT OR AUTHORIZATION.