CALIFORNIA ADVANCE HEALTHCARE DIRECTIVE - PAGE 1 OF 8

Explanation

You have the right to give instructions about your own healthcare. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) Select or discharge health care providers and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures and programs of medication; and
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation;
(e) Make anatomical gifts, authorize an autopsy, and direct the disposition of your remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care. After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

INSTRUCTIONS

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(Name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT (OPTIONAL)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(Name of individual you choose as first alternate agent)

(address)

(city) (state) (zip code)

(home phone) (work phone)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT (OPTIONAL)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(Name of individual you choose as second alternate agent)

(address)

(city) (state) (zip code)

(home phone) (work phone)

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ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

_ _

_ _

_ _

_ _

_ _

(Add additional sheets if needed.)

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4, 5, OR 6 THAT DO NOT REFLECT YOUR WISHES

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

____

____

____

(6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

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INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

ADDITIONAL INSTRUCTIONS (IF ANY)

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PART 2: INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(7) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (**Initial only one box**)

[ ] (a) **Choice NOT To Prolong Life**
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

[ ] (b) **Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

____

____

____

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

\- -

\- -

\- -

\- -

\- -

(Add additional sheets if needed.)

ORGAN DONATION (OPTIONAL)

MARK THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

PART 3: DONATION OF ORGANS AT DEATH (OPTIONAL)

(10) Upon my death: (mark applicable box)

[ ] (a) I give any needed organs, tissues, or parts,

OR

[ ] (b) I give the following organs, tissues, or parts only

[ ] (c) My gift is for the following purposes:
(strike any of the following you do not want)

(1) Transplant
(2) Therapy
(3) Research
(4) Education

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN (OPTIONAL)

PART 4: PRIMARY PHYSICIAN (OPTIONAL)

(11) I designate the following physician as my primary physician:

(name of physician)

(address)

(city) (state) (zip code)

(phone)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN (OPTIONAL)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address)

(city) (state) (zip code)

(phone)

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SIGN AND DATE THE DOCUMENT AND THEN PRINT YOUR NAME AND ADDRESS

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) SIGNATURE: Sign and date the form here:

_______________ _______________
(date) (sign your name)

____
(print your name)

____
(address)

____
(city) (state) (zip code)

WITNESSING PROCEDURE

(14) WITNESSES: This advance health care directive will not be valid for making health care decisions unless it is either:

(1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or
(2) acknowledged before a notary public.

BOTH OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

ALTERNATIVE NO. 1
STATEMENT OF WITNESSES
I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud or undue influence, (4) that I am not a person appointed as an agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

First Witness:

_______________ _______________
(date) (signature of witness)

____
(printed name of witness)

____
(address)

____
(city) (state) (zip code)

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ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT

HAVE ONE OF YOUR WITNESSES ALSO SIGN AND DATE THIS SECTION AND PRINT THEIR NAME AND ADDRESS

OR

A NOTARY PUBLIC SHOULD FILL OUT THIS SECTION OF YOUR DOCUMENT

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Second Witness:

____________________ ______________________________
(date) (signature of witness)

____
(printed name of witness)

____
(address)

____
(city) (state) (zip code)

ADDITIONAL WITNESS STATEMENT

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

____________________ ______________________________
(date) (signature of witness)

____
(printed name of witness)

____
(address)

____
(city) (state) (zip code)

ALTERNATIVE NO. 2: NOTARY PUBLIC

State of California)
) SS.
County of __________________)

On ____________________ before me,________________________
(insert name of notary public)

personally appeared ____________________________________,
(insert the name of principal)

Who proved to me on the basis of satisfactory evidence to be the person(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the state of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

NOTARY SEAL ____
(signature of notary)

THIS SECTION IS TO BE COMPLETED ONLY IF YOU ARE A RESIDENT IN A SKILLED NURSING FACILITY

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as witness as required by section 4675 of the Probate Code.

____________________ ____________________

(date) (signature)

____

(printed name)

____

(address)

____

(city) (state) (zip code)

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Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

Financial Disclosure

Digestive Care Medical Center, Inc. is a California Medical Corporation which is owned by Dr. Scott Levenson.

Facility charges for procedures performed in this Center are billed to the patient's insurance; and patients are responsible for their copay and deductible as per their individual insurance plan. For patients without medical insurance, payment is requested at the time of service. For financial hardship payment plans may be arranged with the billing office.

PATIENT RIGHTS

The patient has the right to:

1. Treatment without regard to sex, or cultural, economic, educational, or religious background or the source of payment for his care.

2. Considerate and respectful care.

3. The knowledge of the name of the physician who has primary responsibility for coordinating his care and the names and professional relationships of other physicians who will see him.

4. Receive information from his physician about his illness, his course of treatment, and his prospects for recovery in terms he can understand. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

5. Receive the necessary information about any proposed treatment or procedure to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who would carry out the treatment or procedure.

6. Participate actively in decisions regarding his medical care. To the extent permitted by law, this includes the right to refuse treatment.

7. Full consideration of privacy concerning his medical care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

8. Confidential treatment of all communications and records pertaining to his care. His written permission shall be obtained before his medical records are made available to anyone not concerned with his care.

9. Reasonable responses to any reasonable request he makes for services.

10. Reasonable continuity of care and to know in advance the time and location of appointments as well as the physician providing the care.

11. Be advised if physician proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

12. Be informed by his physician or designee of his continuing health care requirements.

13. Examine and receive an explanation of his bill regardless of source of payment.

14. Have all patient's rights explained to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.

15. Express any grievances or suggestions verbally or in writing.

Digestive Care Medical Center, Inc. *1000A Laurel St.-San Carlos, Ca.*

Patient Consent

Physician:
[] Scott D. Levenson, M.D.
[] Roger M. Kao, M.D.
[] Edward Onuma, M.D.
[] Betty Ho, M.D.

Patient Name:______________________________________

Procedure:
☐ Colonoscopy with possible biopsy, polypectomy, control of hemorrhage, photography
☐ Esophagogastroduodenoscopy with possible biopsy, control of hemorrhage, photography
☐ Other ______________________________________ **and** sedation and analgesia

As with all medical procedures, endoscopic examination carries some risks as outlined below:

Gastrointestinal endoscopy is the passage of special instruments into various parts of the gastrointestinal tract, such as the stomach or colon. Through these instruments, we can directly visualize the areas of the gastrointestinal tract into which they are passed. Also, biopsies (samples of tissue) may be taken and polyps (abnormal growths) may be removed. Colonoscopy involves passage of the instrument into the rectum and lower bowel. Esophagogastroduodenoscopy is used to visualize and perform procedures in the esophagus, stomach, and upper portion of the small intestine.

I understand that in order to carry out the examination with the least discomfort, moderate sedation may be given intravenously. An intravenous catheter will be inserted into a vein. Moderate sedation involves the use of drugs which will alter my level of consciousness. These drugs may affect my breathing, swallowing reflexes, and cardiovascular system. Individuals react differently to any medication, but also the state of my physical health influences the action of the medication. I understand that possible side effects or complications may include, but are not limited to, nausea, vomiting, headache, and inflammation of the vein at the intravenous site and allergic reactions to the medication. While all reasonable precautions will be taken, unforeseen reactions or complications may occur. This reaction would be treated immediately as needed. More serious heart and lung reactions also may occur. Although rare, there is a remote risk of death, paralysis, or brain damage associated with the administration of moderate sedation.

The type and rate of possible complication varies with the procedure, but certain complications may arise from all of them. Whenever an instrument is introduced into the gastrointestinal tract, there is always a risk of perforation which refers to creating a hole through the wall of an organ. If a perforation occurs, its treatment may vary from observation in the hospital to immediate surgery. Bleeding is another recognized potential complication of endoscopy and may require repeat procedure to stop the bleeding, transfusion of blood and blood products, and/or surgery. Regurgitation of stomach contents can occur resulting in inhaling of fluid into the lungs (aspiration) and may require hospitalization. Very rarely, one of the more serious complications has resulted in death. The purpose of this consent is not to frighten you but to inform you about potential risks and complications.I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained. Also, I consent to the disposal of any tissues or body parts which may be removed. If complication arises, I agree to be admitted and treated at Sequoia Hospital. I hereby acknowledge and am aware of the fact that my physician has an ownership interest in Digestive Care Medical Center, Inc. I have elected, however, to use this facility. I authorize this Center to disclose complete information concerning the medical findings and treatment of the undersigned from the initial office visit until date of conclusion of such treatment to those individuals who in his/her sole determination are required to receive such information for the purpose of medical treatment, medical quality assurance, and peer review. I understand I have the right to make choices regarding life- sustaining treatment (including resuscitative measures). If I have provided the facility with a copy of my Advance Directive/Living Will/Health Care Proxy then these wishes will be honored. If I do not have or have not provided such a document, then the standard policies of the Center will be followed. In the event of accidental exposure of my blood or body fluids to a physician, contractor, or employee of this facility, I consent to testing for HIV and Hepatitis.

The procedures listed to be performed with moderate sedation and the advantages and disadvantages, risks and possible complications as well as the alternatives have been explained to me by my physician. The physician satisfactorily answered my questions. **I also am aware that I am not to drive, operate dangerous machinery, make important decisions, or sign legal documents for 24 hours after receiving sedation.**

Date:____________________ Signature:______________________________________

Time:____________________ If signed by other than patient, indicate relationship

Witness:____________________ ____________________________

PATIENT COMPLAINTS

PROCEDURE

To establish direct communication between patients with complaints and the Center Management

1) Patients who have a complaint regarding Digestive Care Medical Center, Inc. services or care should take their complaint to the Nursing Director, either directly or through an appropriate employee of the Center.

2) The Center, upon receipt of the complaint or upon obtaining knowledge of the fact that a patient has complained, will cause the complaint to be investigated and take appropriate action to resolve the complaint. The patient will be notified of the result of the investigation.

3) The complaints will be filed with the Nursing Director. The Nursing Director and the Quality Improvement Committee will work toward resolution with the patient. If the patient is not satisfied, the matter will be addressed at the Governing Body meeting. A written summary will be included in the minutes, and patient notified in writing of resolution.

Complaints may also be filed with –

Department of Managed Care
980 9th St Suite 500
Sacramento, CA 95814-2725

1-888-466-2219