A Division Of:
Advanced Internal Medicine Group, PC
Dr. Leon Schwechter | Dr. Javier Morales | Dr. Craig Grobman
2200 Northern Boulevard, Suite 133
East Hills, New York 11548 Tel:
516-352-8100 | Fax: 516-352-7348

Primary Care Patient

Dear New Patient:

We welcome you to our practice and look forward to a long and healthy relationship.

As you may know, our practice concentrates on very individualized care for each and every patient. Advanced Internal Medicine Group is known for the time given to each patient according to individual needs.

We concentrate on preventive medicine and early detection of any illness thus minimizing any effects the disease may have on the body. Good health and quality of life are our primary goals.

To help us achieve these goals, please **complete the enclosed medical history questionnaire and return if via fax at (516) 918-9039**. Have all current medications available at the time of the appointment. This will help us focus on your health and associated problems during our visit.

PLEASE REMEMBER TO HAVE YOUR INSURANCE CARDS AVAILABLE SO WE CAN MAKE A COPY FOR OUR RECORDS.

Also enclosed please find our cancellation policy and patient financial responsibility form. Unfortunately, we have found it necessary to institute such a policy for optimum use of our schedule and patient care. Please sign and return the cancellation policy and patient financial responsibility form as soon as possible.

Should you have any questions or concerns, please feel free to call our office. We are in the office on Monday from 10am to 8 pm, and 9 am to 5pm on Tuesday, Wednesday, Thursday. We are closed Friday-Sunday. **If there is an emergent situation, please call the office and press option 2 or directly follow the prompts.** Your emergency will be addressed as soon as the physician is alerted. Our staff is available to assist you in any way possible.

Sincerely yours,

Providers and Staff

I give my consent for Advanced Internal Medicine Group, P.C. to all of the listed requests below. Please initial next to each one and sign on the bottom.

Controlled Substance Monitoring-

Patients agree to take medications only as prescribed and also agree to notify the physician if the patient does not comply. By agreeing to take the medications as directed, patient is agreeing to random urine and/or blood test to assess compliance. Patient understands that random urine drug screens may be performed at any given office visit to monitor

_____ prescribed medication. Lost, stolen, or misplaced prescriptions will NOT BE REPLACED.

Immunization-

_____ I agree to release my immunization(s) record(s) to New York State Immunization Information System (NYSIIS).

Patient Financial Responsibility Form

If your insurance plan requires a copay, then your copay will be collected in the office at the time of service. If that EOB states that you have further responsibility for non-covered services such as co-insurance, deductibles or checks from the insurance company that has been sent directly to you, we will mail you a statement reflecting the

_____ remaining balance which is due upon receipt.

Cancellations-

If an appointment for a missed or cancelled with less than 24 hours notice, the patient will be responsible for a $250 charge, which is not covered by the insurance carrier. If you believe there is good cause for cancellation,

_____ please tell the Care Coordinator immediately so that the practice can take it under consideration.

CCM-

If you are a patient with two or more chronic conditions, or develop two or more chronic conditions, and if you have Medicare you will be enrolled in a program known as Chronic Care Management. We will bill Medicare for providing you with chronic care management up to once a month. If your secondary doesn't participate, you may

_____ be charged a coinsurance.

Fees for Injections -

All Injections are put through insurance (Except tetanus, as no insurance covers this). If your insurance does not cover the shot you will be responsible for the cost. If you have any questions on the injection you receive please

_____ do NOT hesitate to speak with our billing department.

Fees for Patient Testing -

Your doctor may want to perform various methods of testing which all are submitted to your Insurance. Your responsibility for these costs are the same as your general financial responsibility. You may at any time refuse

_____ testing or discuss possible costs with our billing department.

_____ _____

Signature Date

Insurance Information Sheet

Please be sure to complete and return this Insurance Information Sheet with your new patient packet. If you cannot attach your insurance information below, please email a copy to **billing.aimgroup@gmail.com**

Primary Insurance

Attach copy of Primary Insurance here

Secondary Insurance

Attach copy of Secondary Insurance here.

If you do have any tertiary insurance please attach it to this sheet as well. If you have any questions, please do not hesitate to contact our Billing department or speak with one of our Care Coordinators.

COMPLETED BY:_____RELATIONSHIP TO PATIENT: _____

PATIENT NAME:_____DATE:_____

ADDRESS:_____CITY:_____STATE:_____ZIP: _____

PHONE HOME:_____WORK:_____CELL: _____

SS#:_____EMAIL:_____DATE OF BIRTH: _____

WOULD YOU LIKE US TO ENABLE YOU TO USE OUR PATIENT PORTAL TO ALLOW YOU TO FOLLOW YOUR MEDICAL PROGRESS? Y / N

Whom can we thank for this referral_____

Name of Insurance Carrier:_____Please discuss with office staff prior to visit

Date	Please list any Surgeries

Date	Please list any Medical Conditions

Medications with Dose and Frequency Include Over the Counter and Vitamin/Supplements		

Medical History Form

Name:_____ Date:_____

Drug Allergies (or side effects/reactions) -_____

_____

For diabetic patients only:

Have you had a retinal eye exam in the past two years? Yes_____No____If yes, by whom? _____

Habits-Smoking- Do you smoke now?_____Ever? _____

How much?_____If yes_____packs per day?_____

Occupation: _____

Exercise:_____Yes._____No. If yes--How many times per week?_____

Caffeine intake:_____cups per day.

Family History-Place X in appropriate boxes and/or fill in information									
Relative	**Alive**	**Deceased**	**Age**	**Cancer**	**Diabetes**	**Heart**	**Hypertension**	**Mental Illness**	**Stroke**
Father									
Mother									
Siblings									
Children									

Preventative Medical/Immunization History-*Place X where appropriate and fill in date*							
	Pneumovax	**Flu Vaccine**	**Tetanus**	**Zostavax Shingles vaccine**	**Colonoscopy**	**Mammogram**	**Bone Density**
Yes							
No							
Year done							

How often do you have a drink containing alcohol?

☐Never ☐Monthly ☐2-4 times per month ☐2-3 times a week ☐4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

☐1 or 2 ☐3 or 4 ☐5 or 6 ☐7 to 9 ☐10 or more

How often do you have six or more drinks on one occasion?
☐Never ☐Less than monthly ☐ Monthly ☐Weekly ☐Daily or almost daily

Tobacco history
*Do you smoke now?*_____*Ever*?_____*How much*?_____*If yes*_____*packs per day*?_____

During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Yes ☐ No Comments:

During the past 4 weeks, have you experienced bodily pain in general?

☐Yes ☐No Comments:

During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you got sick and had to stay in bed, needed some help with daily chores, or needed help just taking care of yourself?

☐Yes ☐No Comments:

In the past 7 days, did you exercise for at least 3 of them?

☐Yes ☐No Comments:

On days when you exercised, for how long (in minutes)?_____minutes per day

Can you get places out of walking distance without help? ☐Yes ☐No

Can you shop for groceries or clothes without help? ☐Yes ☐No

Can you prepare your own meals? ☐Yes ☐No

Can you do your own housework without help? ☐Yes ☐No

Can you handle your own money without help?	☐ Yes	☐No
Do you need help eating, bathing, dressing, or getting around your home?	☐Yes	☐No

During the past 4 weeks, would you consider yourself in good health?

☐Yes ☐ No Comments:

In the past 4 weeks, would you say things have been going well for you?

☐Yes ☐No Comments:

Are you having difficulties driving your car?

☐Yes ☐No Comments:

Do you always fasten your seatbelt when you are in a car?

☐Yes ☐No Comments:

How often during the past 4 weeks have you been bothered by any of the following problems?

Fall or dizzy when standing up	☐Yes	☐No
Trouble eating well	☐Yes	☐No
Teeth or dentures	☐Yes	☐No
Hearing or problems using the telephone	☐Yes	☐No
Tired or fatigued	☐Yes	☐No

Are you taking your medications the way you were instructed to?

☐Yes ☐No Comments:

Are you confident that you can control and manage most of your health problems?

☐Yes ☐No Comments:

Is stress a problem for you in handling things such as your health, your finances, your family, social relationships, or your work?

☐Yes ☐No Comments:

In the past 2 weeks have you felt nervous, anxious, or on edge?

☐Yes ☐No Comments:

In the past 2 weeks, were you not able to stop worrying or control your worrying?

☐Yes ☐No Comments:

How many hours of sleep do you usually get?_____hours

Do you snore or has anyone told you that you snore? ☐Yes ☐No

Please choose one of the following : (Fall screening)

1. Have you fallen in the past year? ☐Yes ☐ No
2. One fall with injury in the past year? ☐Yes ☐ No
3. Two or more falls in the past year? ☐Yes ☐ No
4. One fall without injury in the past year? ☐Yes ☐ No
5. Two or more falls without injury in the past year? ☐Yes ☐ No

Please list any other current physicians and their specialty:

Physician: (ie: First, Last)	City Office is Located in:	Specialty:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Name _____

Date _____

(NOW OR IN THE RECENT PAST)

General	No	Yes
Fever		
Chills		
Sweats/Night Sweats		
Fatigue		
Weight Loss		
Weight Gain		
HEENT		
Headaches		
Visual Changes		
Dizziness		
Nasal Discharge		
Vertigo (spinning)		
Hoarseness		
Hearing Changes		
Ear Pain		
Nose Bleed		
Ringing in the Ears		
Sore Throat		
Cardiovascular		
Chest Pain		
Shortness of Breath With Exertion		
Swelling in Legs		
Exertional Sweats		
Leg Cramps when Walking		
Respiratory		
Congestion		
Shortness of Breath		
Expectoration (Producing Phlegm)		
Cough		
Coughing up Blood		
Shortness of Breath while lying flat		
Wheezing		
Gastrointestinal		
Abdominal Pain		
Nausea/Vomiting		
Diarrhea		
Constipation		
Change in bowel habits		
Anorexia		
Trouble Swallowing		
Rectal Bleeding		
Reflux		

(NOW OR IN THE RECENT PAST)

Genitourinary	No	Yes
Sudden Urge to Urinate		
Frequent Night Time Urination		
Incontinence		
Blood in Urine		
Difficulty Urinating		
Frequency of Urination		
Painful Urination		
Musculoskeletal		
Serious Joint/Bone Injuries		
Back Pain		
Joint Stiffness		
Muscle Pain		
Painful Joints		
Swollen Joints		
Hematology		
Anemia		
Prolonged Bleeding		
Recent Transfusion		
Swollen Lymph Nodes		
Skin		
Ulcers		
Psoriasis		
Blistering of Skin		
Discoloration		
Hives		
Itching		
Moles		
Rashes		
Neurologic		
Confusion		
Weakness		
Uncoordinated Movement		
Trouble Maintaining Balance		
Difficulty Speaking		
Fainting		
Memory Loss		
Seizures		
Tingling/Numbness		
Tremors		
Psychiatric		
Disorientation		
Anxiety/Agitation		
Hallucination		
Depression		
Insomnia		

Medical History Form

Pharmacy Information

Name of Pharmacy _____

Address _____

Phone #_____Fax # _____

****If your pharmacy has any questions regarding your prescriptions i.e medication refills, please make your pharmacy aware they **MUST** call our office and speak to one of our Care Coordinators. Our office **does not** receive Escript medication requests/refills._____**(Patient initials)***

Emergency Contact Information

Name_____Relation_____

Address_____

Phone #_____

Health Care Proxy Information (if you are not aware of what this is, please ask the Provider)

Name_____Relation_____

Address_____ Phone #_____

Race and Ethnicity questions: **The following questions are required to be asked by Medicare. You may answer or decline to answer, but we must place an answer in your medical chart.**

Race **(**check one**)**

White_____ Hispanic____ Black____ African American_____ Asian____

Native Hawaiian or Pacific Islander_____ Other Pacific Islander_

American Indian Alaskan Native_____ Decline to answer_____

Ethnicity **(**check one**)** Hispanic or Latino_____Not Hispanic or Latino_____Decline to Answer _____

Preferred Language _____

Do you consent to release prescription data to your doctor from external sources? Y? / N?

Do you consent to release your medical information if needed to help adjudicate a claim dispute? Y? / N? Do you consent to report your immunizations? Y? N?

Patient Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Keeping your health information confidential and secure and using it only as permitted by law is a top priority of Advanced Internal Medicine Group, P.C. You have the right to know how Advanced Internal Medicine Group, P.C. uses and discloses your health information. Under the Health Insurance Portability and Accountability Act (HIPAA), Advanced Internal Medicine Group, P.C. can use your health information for Treatment, Payment and Health Care Operations. In connection with "Treatment", we may use or disclose your health information to other physicians or other healthcare providers who may be treating you. In connection with "Payment", we may use and disclose your health information to facilitate payment by health insurers. In connection with "Health Care Operations", we may use and disclose your health information to facilitate our business operations. We may also contact you by telephone to remind you of appointments.

Certain uses and disclosures that do not fall under Treatment, Payment, or Healthcare Operations will require your written authorization. For example, if you would like us to send information to an employer, your written authorization may be required. If you wish us to discuss your information with a family member, it will require your written authorization.

We value our patients and the various rights afforded to them under federal and state law to access health information. We recognize and will accommodate patients' rights to restrict the disclosure of health information. We will also accommodate patients' rights to receive confidential communications of their health information. If you wish a copy of this Notice of Privacy Practice, one will be provided.

Advanced Internal Medicine Group, P.C. values its patients. In the event there are any issues or problems regarding the way your health information was handled by us, you may submit them to us in writing or contact our Practice Manager.

PRIVACY NOTICE ACKNOWLEDGEMENT

I,_____, acknowledge that I have been offered a copy of the Notice of Privacy from Advanced Internal Medicine Group P.C. and understand my patient rights.

Date: _____

_____
Signature

_____
Print Name

ASSIGNMENT OF BENEFITS

I authorize and assign directly all payments for my medical care to Advanced Internal Medicine Group, PC. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Should payment be sent to me, I will send both the payment and the explanation of benefits to Advanced Internal Medicine Group, PC in a timely manner.

Date:_____

_____
Signature

_____
Print Name

RECORDS RELEASE AUTHORIZATION

TO_____

DOCTOR OF HOSPITAL

_____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Advanced Internal Medicine Group, P.C.
D.B. A. AIM HOUSE CALLS
2200 Northern Boulevard, Suite
133 East Hills, NY 11548
516-352-8100
Fax (516) 918-9039

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION. CONCERNING MY ILLNESS AND/OR

TREATMENT DURING THIS PERIOD FROM_____TO_____

NAME_____DATE_____

ADDRESS _____

SIGNATURE_____WITNESS_____

(IF RELATIVE, STATE RELATIONSHIP)

Health Care Proxy

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document.
Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.

2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.

3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.

4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.

5. You do not need a lawyer to fill out this form.

6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.

7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.

10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.

11. Appointing a health care agent is voluntary. No one can require you to appoint one.

12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care

Frequently Asked Questions, *continued*

agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe

deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.**

Can my health care agent make decisions for me about organ and/or tissue donation?

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; or a guardian appointed by a court prior to the donor's death.

Health Care Proxy Form Instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse , if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: _____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

To include all decisions including artificial hydration and nutrition

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1
(print) _____

Name of Witness 2
(print) _____

Signature _____ Signature _____

Address _____ Address _____

_____ _____

NEW YORK
state department of
HEALTH