SHIELD MEDICAL GROUP
QUICK, COMPREHENSIVE AND COST EFFECTIVE CARE

PATIENT SELF DETERMINATION QUESTIONNAIRE

Shield Medical Group honors the state of Florida's stance encouraging the use of Advance Directives. Shield Medical Group will provide, to any patient who states they do not have an Advance Directive, a copy of the Advance Directive packet prepared by the Florida Agency for Health Care Administration (AHCA) and/or a Five Wishes® Advance Directive from Aging With Dignity. If you do have an Advance Directive, Shield Medical Group encourages you to provide us with a copy so we can place it in your medical record. Shield Medical Group will not require you to execute an Advance Directive or to execute a new Advance Directive using the AHCA forms available through Shield Medical Group. In order to comply with Federal and State law, Shield Medical Group uses this questionnaire to document in your medical records whether or not you have executed an Advance Directive.

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

☐ I have made such a declaration

☐ I have NOT made such a declaration

Health Care Surrogate

☐ I have designated a Health Care Surrogate

☐ I have NOT designated a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney

☐ I have NOT appointed a Durable Power for Health Care decisions

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

_____

Full Name (Print) Date of Birth Social Security Number

Signature: _____ Date: _____

Patient or Patient Representative

Relationship of Patient Representative (if applicable):_____

YEARLY RECONFIRMATION: I acknowledge that this information remains accurate.

_____

Signature of Patient or Patient Representative Date

_____

Signature of Patient or Patient Representative Date

_____

Signature of Patient or Patient Representative Date

_____

Signature of Patient or Patient Representative Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Patient Representative: _____ Date: _____

Relationship of Patient Representative (if applicable):_____