Patient Rights and Responsibilities

NSPC Rev. 1/2024

The Northway Surgery and Pain Center

1596 Route 9, Halfmoon, NY 12065 (518) 371-6772

Title: Patient Rights and Responsibilities

Policy: The patient's treatment begins with the first employee they meet. Nothing is more important than every member of the staff being caring, courteous, friendly, helpful, and prompt in the attention accorded patients. The facility does not discriminate on the basis of age, race, color, sexual orientation, religion, marital status, sex, national origin, or sponsor. NORTHWAY SURGERY and PAIN CENTER will inform the patient or the patient's representative of the patient's rights, prior to the start of the procedure will provide both verbal and written notice of the patient's rights in a language and manner that the patient, the patient's representative or surrogate understands all of the patient's rights.

1. **Patient Rights:**

At the center, we believe that our patients have the following rights:

(1) Receive services(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor; Be free from any act of discrimination or reprisal;

(2) Be treated with consideration, respect and dignity including privacy in treatment; Patients receive personal privacy and safe physical surroundings while in the surgical center, safe from all forms of abuse and /or harassment;

(3) Be informed of the services available at the center;

(4) Be informed of the provisions for off-hour emergency coverage;

(5) Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;

(6) Receive an itemized copy of his/her account statement, upon request;

(7) Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to 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.

(8) Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision; Be fully informed about a treatment or procedure and the expected outcome before it is performed;

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;

(10) Refuse to participate in experimental research;

(11) Voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;

(12) Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health's Office of Primary Health Systems Management;

By Mail:

New York State Department of Health
Centralized Hospital Intake Program
Mailstop: CA/DCS
Empire State Plaza
Albany, NY 12237

By Phone: 1-800-804-5447

To Medicare: via the Office of the Medicare Beneficiary Ombudsman via https://www.medicare.gov/claims-appeals/your-medicare-rights/get-help-with-your-rights-protections

For accreditation Inquiries: AAAHC 5250 Old Orchard Road, Ste 200
Skokie, IL 60077
Phone: 847-853-6060

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment;

(14) Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;

(15) Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and

(17) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center;

(18) If a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf. If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law;

(19) Credentials of health care providers will be available to patients and staff

(20) Be informed of their right to change providers if other qualified providers are available.

2. Patient Responsibilities:

At the center, we believe that our patients have the following responsibilities:

a. It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur;
b. Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
c. The patient is expected to follow his/her doctor's treatment plan, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels is necessary;
d. **Answer Questions Fully.** You or your designated representative had the responsibility to provide an accurate and complete history in order for you to receive effective treatment. To provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over the counter products and dietary supplements and any allergies or sensitivities and their reactions. This includes authorizing release of health records from previous health care providers;
e. **Cooperate and Communicate with Providers.** You have the responsibility to participate in discussions and ask questions about your care. You have the responsibility to request further information concerning anything you do not understand, regarding your illness or condition and its treatment. You have a responsibility to obtain and carefully consider all information you may need to give an informed consent for treatment and weigh the consequences of refusing treatment;
f. The patient is responsible to inform his/her provider of any living will, medical Power of Attorney, or other Health care directives that could affect his/her care;
g. The patient has the responsibility to provide a responsible adult to transport him/her from the facility and remain with him/her for 24 hours, as required by his/her provider;
h. **Respect and Consideration**. You have a responsibility to respect all the healthcare professionals and staff. You have a responsibility to notify your provider, as soon as possible, if you must be late or cancel a scheduled appointment;
i. **Financial Obligations**. You have the responsibility for the costs of your care and treatment. You are responsible for assuring the financial obligations of your care are fulfilled. You have a responsibility to adhere to the guidelines of your insurance coverage regarding referral policies; You have the responsibility to accept financial responsibility for any charges not covered by your insurance;
j. **Conduct.** To conduct oneself in a respectful manner and give consideration to other patients and Health Care Providers/staff.

Patient Rights Special Circumstances:

If a patient is adjudged incompetent under applicable State Health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under New York state law to act on the patient's behalf.

If a New York State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with New York State law may exercise the patient's rights to the extent allowed by New York State law.

The booklet containing the patient's right policy is given to and reviewed with the patient, the patient's representative or the patient's surrogate at the time of admission, prior to the start of surgery/procedure.

Resources for Patients' Rights and Responsibilities:

"Official Compilation Codes/Rules and Regulations of the State of New York/Title 10 Health 2006: Chapter V Medical Facilities"; Part 751.9.
"Accreditation Association for Ambulatory Health Care, Inc."

This policy will be prominently posted in patient care areas.

THE NORTHWAY SURGERY and PAIN CENTER is owned and operated by the following physicians. They designed and built the center for the high-quality care, comfort and convenience of pain management patients in the Capital District of New York. The physicians know you have a choice of where you have your surgery and thank you for choosing NSPC.

Martin G. Ferrillo, DO
Charles F. Gordon, MD

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.

The Northway Surgery and Pain Center (NSPC) is committed to protecting your privacy. As a healthcare provider, we know your trust in us is of central importance. This policy discloses our information use policies and practices in detail. Please read it to learn more about the ways we protect your health information, and to find out how you can limit the information about you that is shared.

Uses and disclosures of health information for Treatment, Payment and Health Care Operation

We may use or disclose identifiable health information about you without your authorization for treatment, to obtain payment for treatment, for purposed of health care operations and to evaluate the quality of care you receive.
Treatment: We will use and disclose your health information to provide, coordinate or manage your health care and any related services. For example, we would disclose your health information, as necessary, with Albany and Saratoga Centers for Pain Management or New York Pain Management in order to correctly book your procedure.
Payment: Your health information will be used, as needed, to obtain payment for your care services. This may include certain activities that your health care insurance plan may undertake before it approves or pays for the health care services we provide, such as making a determination of eligibility or coverage, reviewing services provided for medical necessity, and undertaking utilization review activities. For example, we may disclose information to your health plan in order to obtain authorization for your procedure.
Healthcare Operations: We may disclose, as needed, your health information in order to perform a variety of administrative activities. These activities include, but are not limited to: quality assessment activities, training, cooperating with outside organizations that evaluate, certify or license healthcare providers or facilities, and resolution of grievances within our own organization. For example, members of the medical staff may use information in your health record to evaluate the quality of care provided to you. We may also share your health information with third party "business associates" that perform various activities for us, such as lawyers, accountants and other consultants. To protect the privacy of your health information, we require our business associates to appropriately safeguard your information.

Other Permitted and Required Uses and Disclosures

We will use and disclose your health information without your authorization whenever we are required by law to do so. We may also use or disclose your health information without your authorization for certain "national priority: purposes including:

To state and federal authorities for public health activities, including but not limited to, activities related to investigating diseases, monitoring drugs and devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries;

To government authorities, including protective services agencies, authorized to receive reports of abuse, neglect or domestic violence;

To government health oversight agencies, such as the U.S. Department of Health and Human Services, Medicare/Medicaid Peer Review Organizations, state Boards of Medicine, Nursing, Pharmacy, and other licensing authorities;

When required by law in a judicial or administrative proceeding;

To law enforcement officials for certain purposes, including the reporting of certain types of wounds or injuries, or pursuant to legal process to identify or locate a subject, fugitive, material witness, missing person or victim;

To coroners, medical examiners or funeral directors for purposes of carrying out their duties as required by law;

To organ procurement organizations for the purposes of organ or tissue donation and transplantation;

For research approved by an Institutional Review Board (IRB) or Privacy Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information;

When required to avert a serious threat to health or safety;

When required for certain specialized government functions authorized by law, including military and national security and intelligence activities;

As authorized by law in connection with Worker's Compensation programs.

Other than the uses and disclosures described above, we will not use or disclose your health information without your written authorization. If you sign a written authorization allowing us to disclose your health information, you may later revoke that authorization in writing. If you revoke your authorization, we will follow your instructions except to the extent that we have already acted upon your written authorization.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

Right to a copy of this Notice: You have a right to have a paper copy of our Notice of Privacy Practices at any time. In
addition, a copy of this Notice will always be posted in our waiting area.

Right of Access: In most cases you have the right to look at or get a copy of your medical record if you provide us with a written request. We will charge you $0.75 (seventy-five cents) for copying each page.

Right to an Accounting: You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Right of Correction and Amendment: If you believe that information in your record is incorrect or if you believe important information is missing, you have the right to request that we correct the existing information or add the missing information. We have the right to deny your request and, if we do, we will explain in writing our reason for doing so. You will have the opportunity to send us a statement explaining why you disagree with our decision and we will share your statement whenever we disclose your health information in the future.

Right to request restrictions: You may request in writing that we not use or disclose your information for treatment, payment and health care operations except when specifically authorized by you, when required by law or in emergencies. We will consider your request but are not legally required to accept it. If we do agree to your request, we will follow your instructions. You may cancel your restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation, but we will continue to apply your restrictions to any information we received before the cancellation.

Right to request alternative method of contact: You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than your home address. We will agree to abide by any reasonable request for alternative methods of contact. You must provide us with your request in writing.

Complaints

If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access or correction to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person below can provide you with the appropriate address upon request.

If you decide to contact the undersigned person with a complaint, or if you send a written complaint to the U.S. Department of Health and Human Services, you will not suffer any retaliation.

Our Legal Duty.

We are required by law to protect the privacy of your information, provide this notice of our information practices and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:
Privacy Officer, The Northway Surgery and Pain Center, 1596 Route 9, Halfmoon, NY 12065.

http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Northway Surgery and Pain Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak limited English, language assistance services, free of charge, are available to you. Call 1-518-371-6772.

Español (Spanish)

Northway Surgery and Pain Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-518-371-6772.

Tiếng Việt (Vietnamese

Northway Surgery and Pain Center tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-518-371-6772.

繁體中文 (Chinese)

Northway Surgery and Pain Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-518-371-6772.

한국어 (Korean)

Northway Surgery and Pain Center은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-518-371-6772 번으로 전화해 주십시오.

Русский (Russian)

Northway Surgery and Pain Center соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-518-371-6772.

Tagalog Filipino Sumusunod ang Northway Surgery and Pain Center sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-518-371-6772.

العربية **Arabic**

يلتزم [Northway Surgery and Pain Center] بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس. ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم:1-518-371-6772).

Kreyòl Ayisyen (French Creole)

Northway Surgery and Pain Center konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-518-371-6772.

Français (French) Northway Surgery and Pain Center respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-518-371-6772.

Polski (Polish) POLISH

Northway Surgery and Pain Center postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-518-371-6772.

Italiano (Italian) ITALIAN

Northway Surgery and Pain Center è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in

essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-518-371-6772.

[قابلِ اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل Northway Surgery and Pain Center **URDU**] اُردُو (Urdu)

کرتا ہے اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتخبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-518-371-6772

קומט נאך פעדעראלע ציווילע רעכטן געזעצן און דיסקרימינירט נישט Northway Surgery and Pain Center (Yiddish אידיש

אויפן באזיס פון ראסע, קאליר, נאציאנאלע אפשטאם, דיסאביליטי, אדער געשלעכט

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-518-371-6772.

GREEK (Greek) λληνικά

Η Northway Surgery and Pain Center συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-518-371-6772

Srpsko-hrvatski (Serbo-Croatian) Northway Surgery and Pain Center pridržava se važećih saveznih zakona o građanskim pravima i ne pravi diskriminaciju po osnovu rase, boje kože, nacionalnog porijekla, godina starosti, invaliditeta ili pola.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-518-371-6772.

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, eye 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, eye 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.

Frequently Asked Questions, *continued*

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 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.

Frequently Asked Questions, *continued*

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 decide in advance 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, eye and/or tissue donation?
Yes. Use the optional organ, eye and/or 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, eyes 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, eye and/or tissue donor.**

Can my health care agent make decisions for me about organ, eye 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, eye 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, eye and/or tissue donation to your health care agent, or "health care proxy," family members, and the person responsible for disposition of your remains. If you have not already made your wishes to become, or not to become, an organ and/or tissue donor known, New York Law provides a list of individuals who are authorized to consent to organ, eye and/or tissue donation on your behalf. They are listed as follows, in order of priority: your health care agent/proxy; 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; an adult grandchild; a grandparent; a guardian appointed for you by a court prior to your death; or any other person authorized to dispose of your body.

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, eye and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ, eye and/or tissue donation on your behalf: your designated health care agent/ proxy; your designated agent to control the disposition of your remains; 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; an adult grandchild; a grandparent; a guardian appointed by a court prior to your death; or any other person authorized to dispose of your body.

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):*

_____

_____

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, Eye and/or Tissue Donation

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

☐ Any needed organs, eyes and/or tissues

☐ The following organs, eyes and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ, eye 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.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Department of Health

Medical Orders for Life-Sustaining Treatment (MOLST)

This Medical Orders for Life-Sustaining Treatment (MOLST) form is generally for patients with advanced illness who require long-term care services and/or who might die within 1-2 years.* The MOLST may also be used for individuals who wish to avoid and/or receive specific life-sustaining treatments. A physician, nurse practitioner, or physician assistant reviews the patient's current health status, prognosis, goals for care, and the risks and benefits of each life-sustaining treatment with the patient if they have capacity, or the health care agent or surrogate if the patient lacks capacity.

All ethical and legal requirements must be followed, including special procedures when a patient has an intellectual or developmental disability and lacks capacity. If the patient has an intellectual or developmental disability (I/DD) and lacks the capacity to decide, the physician (not a nurse practitioner or physician's assistant) must follow special procedures and attach the completed Office for People with Developmental Disabilities (OPWDD) MOLST Legal Requirements Checklist for Individuals with I/DD before signing the MOLST. (OPWDD checklist available at **https://opwdd.ny.gov/providers/health-care-decisions**). For more information on requirements for completing the MOLST, see page 4.

This MOLST may not be changed without the consent of the patient (or their health care decision-maker if the patient lacks capacity). Completing a MOLST is voluntary and cannot be required. The patient should keep this original MOLST with them at all times, whenever they leave home and during travel to different care settings. The physician, nurse practitioner, or physician assistant keeps a copy. All health care professionals and emergency medical services (EMS) providers are required to follow these medical orders. HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment. For further information on MOLST, see **https://www.health.ny.gov/professionals/patients/patient_rights/molst/**

SECTION A Patient Information

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS/CITY/STATE/ZIP

PREFERRED PHONE NUMBER | DATE OF BIRTH (MM/DD/YYYY) | eMOLST NUMBER (THIS IS NOT AN eMOLST FORM)

Check All Advance Directives Known to be Completed

☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of an Oral Advance Directive

SECTION B Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check **one:**

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**

SECTION C Orders for Life-Sustaining Treatment When the Patient Has a Pulse and is Breathing

Respiratory Support: Non-invasive Ventilation and/or Intubation and Mechanical Ventilation

Check **one:**
- ☐ Intubation and long-term mechanical ventilation, includes tracheostomy
- ☐ A trial of non-invasive ventilation and/or intubation and mechanical ventilation*
- ☐ A trial of non-invasive ventilation only; if fails, Do Not Intubate*
- ☐ Do Not Intubate (DNI) and Do Not Use Non-invasive Ventilation or Mechanical Ventilation

Future Hospitalization/Transfer

Check **one:**
- ☐ Send to the hospital, when medically necessary
- ☐ Send to the hospital only if pain and severe symptoms cannot be controlled
- ☐ Do not send to the hospital

SECTION D Consent for Sections B and C

SIGNATURE OF INDIVIDUAL MAKING DECISIONS | PRINTED NAME OF INDIVIDUAL MAKING DECISIONS

☐ Verbal consent, leave signature line blank

DATE/TIME OF CONSENT

Who is the individual making decisions:

☐ Patient ☐ Health Care Agent ☐ FHCDA Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate for individual with I/DD

PRINTED NAME OF FIRST WITNESS* | PRINTED NAME OF SECOND WITNESS

*If this decision relates to an individual with an intellectual or developmental disability, refer to the instructions on page 4 before proceeding.

SECTION E Physician/Nurse Practitioner/Physician Assistant Signature for Sections B and C

If Section D is completed by a §1750-b Surrogate, a physician must sign this Section E. Prior to the physician signing this Section E when Section D is completed by a §1750-b Surrogate, the physician must complete and attach the OPWDD Checklist.

SIGNATURE | PRINT NAME

LICENSE NUMBER | DATE/TIME

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT | DATE OF BIRTH (MM/DD/YYYY)

SECTION F Additional Orders for Life-Sustaining Treatment

TREATMENT GUIDELINES

Check **one:**

☐ No limitation on medical interventions
☐ Limited medical interventions, only as described below
☐ Comfort measures only. Provide medical care and treatment with the primary goal of relieving pain and other symptoms

ARTIFICIALLY ADMINISTERED FLUID AND NUTRITION

FEEDING TUBE

Check **one:** ☐ Long term feeding tube
☐ Determine use or limitation if need arises*
☐ No feeding tube

IV FLUIDS

Check **one:** ☐ IV fluids
☐ Determine use or limitation as need arises*
☐ No IV fluids

ANTIBIOTICS

Check **one:** ☐ Use antibiotics to treat infections
☐ Determine use or limitation of antibiotics when infection occurs*
☐ Do not use antibiotics

DIALYSIS

Check **one:** ☐ Use dialysis to treat renal failure
☐ Determine use or limitation if renal failure occurs*
☐ Do not use dialysis

OTHER MEDICAL ORDERS AND INSTRUCTIONS (only as discussed with the physician, NP, or PA. May include instructions and goals for trials*. If nothing else is discussed, write NONE.)

SECTION G Consent for Section F

SIGNATURE OF INDIVIDUAL MAKING DECISIONS | PRINTED NAME OF INDIVIDUAL MAKING DECISIONS

☐ Verbal consent, leave signature line blank

DATE/TIME OF CONSENT

Who is the individual making decisions:

☐ Patient ☐ Health Care Agent ☐ FHCDA Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate for individual with I/DD

PRINTED NAME OF FIRST WITNESS* | PRINTED NAME OF SECOND WITNESS

*If this decision relates to an individual with an intellectual or developmental disability, refer to the instructions on page 4 before proceeding.

SECTION H Physician/Nurse Practitioner/Physician Assistant Signature for Section F

If consent for this order was provided by a §1750-b Surrogate for an individual with an intellectual or developmental disability, only a physician may sign this section, and only after the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD has been completed and attached.t.

SIGNATURE | PRINT NAME

LICENSE NUMBER | DATE/TIME

This MOLST form has been approved by the NYSDOH for use in all settings.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT DATE OF BIRTH (MM/DD/YYYY)

SECTION I Review and Renewal

A physician, nurse practitioner, or physician assistant should review this form at least every 90 days and whenever the patient or other decisionmaker changes their mind about treatment. The MOLST should also be reviewed if the patient moves from one location to another to receive care, or if the patient has a major change in health status (for better or worse).

This MOLST remains valid and must be followed even if it has not been reviewed in the 90-day period.

Date/Time	Reviewer's Printed Name and Signature	Location of Review	Outcome of Review
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
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			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form
			☐ No change ☐ Form changed, new form completed ☐ Form voided, no new form

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT | DATE OF BIRTH (MM/DD/YYYY)

In addition to the MOLST form, the New York State Department of Health and OPWDD have developed legal requirements checklists and instructions to assist in the proper completion of the MOLST. The checklists are intended to assist providers in satisfying the ethical and legal requirements associated with decisions concerning life-sustaining treatment for all patients.

Adult Patients

The instructions and legal requirements checklists for **adult patients** can be found at **www.health.ny.gov/professionals/patients/patient_rights/molst/**. For adult patients, there are five different checklists. The correct checklist should be chosen based on the patient's decision-making capacity and the setting.

- **Checklist #1** Adult patients with medical decision-making capacity - any setting
- **Checklist #2** Adult patients without medical decision-making capacity who have a health care proxy - any setting
- **Checklist #3** Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy, decision-maker is Public Health Law Surrogate
- **Checklist #4** Adult hospital, hospice or nursing home patients without medical decision-making capacity who do not have a health care proxy and for whom no surrogate from the list is available
- **Checklist #5** Adult patients without medical decision-making capacity who do not have a health care proxy, and the MOLST form is being completed in the community

A Public Health Law Surrogate (aka a FHCDA Surrogate) means a surrogate under Public Health Law Article 29-CC (the Family Health Care Decisions Act).

Minor Patients

The instructions and legal requirements checklists for **minor patients** can be found at: www.health.ny.gov/professionals/patients/patient_rights/molst/

Individuals with Intellectual or Developmental Disabilities (I/DD)

The law governing the decision-making process differs for individuals with I/DD. Surrogate's Court Procedure Act Section 1750-b (SCPA 1750-b) must be followed when making a decision for an individual with I/DD who is determined to lack capacity and who does not have a health care proxy.

- **Sections E and H of this form may only be signed by a physician,** not a nurse practitioner or physician's assistant.
- In sections D and G of this form, **one witness must be the individual's treating physician.**
- Completion of the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD, including notification of certain parties and resolution of any objections, is **mandatory prior to completion of a MOLST.**
- Both the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD and SCPA 1750-b process apply to individuals with I/DD, r**egardless of their age or residential setting.**
- **Decisions to withhold or withdraw life sustaining treatment (LST) for an individual with I/DD** must be specifically listed and described in step 2 of the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD and only after the surrogate has had a discussion with the individual's treating physician regarding their medical condition, possible treatment options and goals for care. SCPA 1750-b also requires that two physicians determine that the individual's condition meets specific medical criteria **at the time the request to withhold or withdraw treatment is being made,** including that the provision of the life sustaining treatment would impose an extraordinary burden on the individual. These requirements are included in step 4 of the OPWDD MOLST Legal Requirements Checklist for Individuals with I/DD. The individual's medical condition for the purposes of a request to withhold or withdraw LST **must never include consideration of their intellectual or developmental disability.**
- Trials for an individual with I/DD: Whether or not a new checklist is required following an unsuccessful trial of LST depends on the parameters of the trial, as specified in step 2 of the OPWDD MOLST Legal Requirements Checklist for individuals with I/DD. **If a trial period is open ended, and the authorized surrogate subsequently decides to request withdrawal of the LST, a new checklist is required.**

The complete instructions and legal requirements checklists for **people with intellectual or developmental disabilities** can be found at: **www.opwdd.ny.gov/providers/health-care-decisions** or at **www.health.ny.gov/professionals/patients/patient_rights/molst/**.