INFINITE HEALTH CARE

INTAKE

Patient Intake Form

Name _____ Date _____

Date of Birth _____ Gender _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____ Phone No _____

Emergency Contact _____ Phone No _____

Martial Status _____ Ethnicity _____

How did you hear about us? _____

MEDICAL HISTORY

Please select any relevant conditions below:

- ☐ Anemia/Blood Disorder
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Condition
- ☐ Blood Clotting Disorder
- ☐ Cancer/History of Cancer
- ☐ COPD
- ☐ Deep Vein Thrombosis
- ☐ Depression/Suicidal Ideation
- ☐ Diabetes/Retinopathy
- ☐ Eating Disorder History
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Headache/Migraine
- ☐ High Blood Pressure
- ☐ HIV/AIDS or Hepatitis
- ☐ Hormone Replacements
- ☐ IBD/IBS
- ☐ Kidney Disorder/Disease
- ☐ Low Blood Pressure
- ☐ Low Libido
- ☐ Mental Health History
- ☐ Neurological Disorder/Stroke
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Renal Failure
- ☐ Sleep Apnea
- ☐ Substance/Alcohol abuse
- ☐ Thyroid Disease

Details or any other condition: _____

Are you allergic to any medications? No Yes If yes, please explain:_____

_____

Have you had surgery or hospitalizations in the past year? No Yes: _____

_____

_____

List any vaccines that you've had in the last year:

_____

Are you currently taking any blood thinning drugs? (i.e., Aspirin and Warfarin) No Yes

If yes, please list them: _____

FEMALE MEDICAL HISTORY

Are you currently: Pregnant Trying to conceive Breastfeeding Post-menopause

Using contraceptives: _____ Other: _____

Date last menses: Pregnancies: Live births:

Please provide a list of all medications or supplements you take:

MEDICATION OR SUPPLEMENTS	DOSE	FREQUENCY	COMMENTS

HEALTH HABITS

Do you smoke? ☐ No ☐ Yes How many per day? _____ How long? _____

Do you drink alcohol on a regular basis? ☐ No ☐ Yes Weekly Use: _____

How is your activity level? ☐ Sedentary ☐ Lightly active ☐ Moderately active ☐ Very active

What methods or interventions have you used to lose weight previously?

☐ Diet ☐ Exercise ☐ Prescription medication ☐ Therapy ☐ Herbal supplements

Date of last physical: _____ Date of last blood work: _____

Relevant results: _____

What is your main motivations and concerns for your visit today?

_____

_____

Have you experienced any of these symptoms recently?

☐ Chest Pain	☐ Vision changes	☐ Suicideal Ideation
☐ Pain with meals	☐ Shortness of Breath	☐ Numbness/Tingling
☐ Poor balance/falls	☐ Change in bowel habits	☐ Confusion/Brain Fog
☐ Unexperienced weight gain/loss	☐ Unusual Pain with Menstruation	Other: _____

By signing below, I acknowledge that I have provided complete and accurate information and understand that it will be used to assess my suitability for any treatment. I understand that it is my responsibility to inform the Medical Practitioner of any changes to my medical history or skincare routine. I agree to waive all liabilities of the Medical Practitioner or employer for any injury or damages incurred due to misrepresentation of my health history.

Client Name (printed)	Client Name (signed)	Date
Provider Name (printed)	Provider Name (signed)	Date

INFINITE HEALTH CARE

RELEASE FORM

photo & video

I, _____ grant and authorize Infinite Health Care, PLLC the right to take, edit, alter, use and publish photographs and/or videos of me for the purpose of promotional materials, including but not limited to:

- Print advertisements
- Online marketing (websites, social media, blogs)
- Educational materials (brochures, flyers, presentations)

I acknowledge that all photographs and/or videos taken are the property of Infinite Health Care, PLLC., and will be used solely for the purposes stated above.

I understand that by signing this release form, I grant Infinite Health Care, PLLC., permission to take, edit, alter, use and publish my photographs and/or videos without any further compensation or consideration. I waive any rights to compensation, financial or otherwise, for the use of these photographs and/or videos.

I release Infinite Health Care, PLLC., its representatives, and employees from any claims, damages or liabilities that may arise from the use of the photographs and/or videos, including any claims for compensation, defamation, or invasion of privacy.

By signing below, I acknowledge that I have read this release form, understand its content, and voluntarily agree to its terms.

Client Name (printed)	Client Name (signed)	Date
Provider Name (printed)	Provider Name (signed)	Date

INFINITE HEALTH CARE

POLICY FORM

cancellation

At Infinite Health Care, we strive to provide an exceptional standard of care. In order to achieve this, we kindly request your cooperation in adhering to our cancellation policy.

We understand that life can be unpredictable and unexpected circumstances may arise. However, we kindly ask that you provide us with at least 24 hours' notice if you need to cancel or reschedule your appointment. Your deposit will be refunded or applied to a new appointment.

Cancellations made within 24 hours of the scheduled appointment time are subject to a $50 cancellation fee.

While we understand that unforeseen circumstances can occur, a missed appointment where no notice is given not only affects our ability to serve other clients but also results in lost time and resources. The full cost of the service is charged for these appointments.

We value your time as well as the time of our other clients. If you arrive more than 15 minutes late for your scheduled appointment, we may need to reschedule your session or shorten the treatment duration. The full price of the originally scheduled appointment will still apply.

We truly appreciate your understanding and cooperation in honoring our cancellation policy to ensure that each client receives the attention and quality service they deserve.

Client Name (printed)	Client Name (signed)	Date
Provider Name (printed)	Provider Name (signed)	Date

INFINITE HEALTH CARE

CLIENT RECORD

Blood Pressure

Name _____

BLOOD PRESSURE	DAY	TIME	COMMENTS

INFINITE HEALTH CARE

CLIENT RECORD

Blood Glucose

Name _____

BLOOD GLUCOSE	DAY	TIME	COMMENTS

INFINITE HEALTH CARE

CONSENT

Consent to Disclose Health Care Information

Patient consent for Provider to use or disclose Health Care information for treatment, payment and health care.

Patient Name: _____ Date of Birth: _____

To give consent to disclose health care information to someone other than the patient, please write their name below: (e.g Family member & caretaker)
NAME: _____ Relation: _____

I understand that my health information is private and confidential. I understand that Infinite Health Care works diligently to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that Infinite Health Care may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the Provider(s) declining to treat me.

Under the terms of this consent, I can ask Infinite Health Care to restrict how my personal health information is used or disclosed to carry out treatment, payment or
health care operations. I understand that Infinite Health Care does not have to agree to my request. If Infinite Health Care does not agree to my request, I understand that the limits agreed upon will be followed.

I understand that I have the right to cancel this consent in writing at anytime. If I do cancel the consent, I understand that Infinite Health Care may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.
I MAY CANCEL THIS CONSENT AT ANY TIME BY DOING THE FOLLOWING:

Writing, signing and dating a letter to Infinite Health Care that states the patient wants to revoke their consent to authorize the use and disclosure of my personal health information for treatment, payment and health care options.
I understand if I cancel this consent, Infinite Health Care is not obligated to provider further health care services to me.

My signature below indicates that I agree to the policies outlines by this document and all statements therein.

_____ _____

Patient or legally authorized individual's signature Date

_____

Relationship to the patient if signed by anyone other than him/her (Parent, legal guardian, personal representative, etc)

INFINITE HEALTH CARE

CONSENT
Treat & Release of Medical Records

Authorization for Treatment

I _____ the undersigned, hereby provide my informed consent to receive medical treatment and services from Infinite Health Care and it's Provider(s), hereinafter referred to as "the Provider". I understand that this consent encompasses any and all medical treatments, procedures, and services that the Provider(s) deems necessary or advisable for my health and well-being.

- Nature of Treatment: I understand that the Provider(s) will offer me appropriate medical treatment and services to address my health condition(s) to the best of their abilities. The specific treatment and services will be determined based on the diagnosis and assessment by the Provider(s).
- Risk and Benefits: I have been provided with information regarding the potential risks, benefits, and alternatives associated with the proposed treatments and services. I understand that the Provider(s) has answered my questions and addressed my concerns to my satisfaction.
- Consent for Medical Records: I authorize the Provider(s) to obtain and release my medical records as necessary for the continuation of my care and treatment, in accordance with applicable laws and regulations.
- Right to Refuse Treatment: I understand that I have the right to refuse any treatment or service recommended by the Provider(s). I acknowledge that by refusing recommended treatment, I may jeopardize my health.
- Privacy and Confidentiality: I understand that my medical information will be treated confidentially and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws and regulations.
- Payment Responsibility: I agree to be responsible for payment for the medical services rendered to me by the Provider(s), including any services not covered by insurance. I understand that I may request an estimate of charges before any non-emergency treatment.
- Advance Directives: I have been informed of my right to create advance directives, such as a living will or durable power of attorney for healthcare, and the Provider(s) policy regarding such directives.
- Telemedicine: I understand that telemedicine services may be provided, and I consent to receive medical care through telemedicine if the Provider(s) deem appropriate.
- Minors and Dependents: For patients under 18 years of age or dependent adults, I represent that I have the legal authority to provide consent for their treatment. The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of the patient.

INFINITE HEALTH CARE

CONSENT
Treat & Release of Medical Records

Release of Information

This authorization, or copy of the same, authorizes the release to the Provider(s) of any medical information necessary for treatment and/or to process claims for services rendered by the Provider(s). The patient or authorized patient representative agrees to execute any documents and perform any acts the Provider(s) may reasonably request with regards to services.

Terms

This patient consent and authorization given to the Provider as set forth above will remain in full force and effect per episode of care until terminated in writing by patient or authorized patient representative. This termination will not be effective until the facility receives this request in writing.
I have had the opportunity to ask questions and clarify any concerns related to my treatment. I understand the information provided to me, and I freely and voluntarily consent to the proposed medical treatment and services.

Patient Consent

Signature of Patient or Patient's Representative

Date

Printed Name

Representative's Relationship to Patient

INFINITE HEALTH CARE

CONSENT
Health Information Exchange

Health Information Exchange (HIE) Consent

At Infinite Health Care, we are committed to providing you with the highest quality of care. To enhance the coordination of your healthcare and ensure that your medical information is readily accessible to authorized healthcare providers when needed, we participate in a Health Information Exchange (HIE) network.
The HIE network allows us to securely share and receive electronic health records (EHRs) with other healthcare facilities, including hospitals, specialists, and primary care providers. This exchange of information is crucial for ensuring that you receive the most comprehensive and timely care possible, especially in emergency situations. To participate in the HIE network, we require your informed consent. By signing below, you acknowledge that you have read and understood the following:

Purpose of the HIE: The primary purpose of the HIE is to improve the quality and coordination of your healthcare by making your medical records available to authorized healthcare providers involved in your treatment.

Security and Privacy: Your medical information will be shared securely and in compliance with all applicable laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). Access to your records will be restricted to healthcare providers directly involved in your care.

Right to Withdraw Consent: You have the right to withdraw your consent for HIE participation at any time. However, please note that this may limit the availability of your medical information to other healthcare providers during your treatment.

Information Shared: They types of information that may be shared through the HIE include, but are not limited to, diagnoses, medication lists, allergies, lab results, and treatment history.

Please indicate your consent or decline to participate in the HIE network by checking the appropriate box below:

☐ I consent to the sharing of my medical information through the Health Information Exchange (HIE) network.

☐ I decline to participate in the Health Information Exchange (HIE) network, and I understand that this decision may limit the availability of my medical information to other healthcare providers.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient

INFINITE HEALTH CARE

CONSENT
Health Information Exchange

Health Information Exchange

Purpose of the HIE: The Health Information Exchange (HIE) is to secure electronic system that allows healthcare providers, such as hospitals, clinics, and healthcare professionals, to access and share my health information for the purpose of providing me with better healthcare services, improving the coordination of my care, and enhancing the quality and safety of my medical treatment.

Information to be Shared: I understand that the following types of health information may be shared through HIE

- ☐ Allergies
- ☐ Authorized Recipients
- ☐ Hospital Discharge Summaries
- ☐ Immunization Records
- ☐ Laboratory Results
- ☐ Medical History
- ☐ Medications
- ☐ Physician Progress Notes
- ☐ Radiology Reports
- ☐ Other relevant health information

Recipients: I understand that the authorized recipients of my health information through the HIE may include but are not limited to:

- ☐ Emergency Medical Services (EMS)
- ☐ Health Plans
- ☐ Hospitals
- ☐ Laboratories
- ☐ Pharmacists
- ☐ Physicians/Providers
- ☐ Radiology Centers
- ☐ Rights and Acknowledgment

Patient Rights and Responsibilities Regarding HIE:

- I have the right to revoke this consent at any time by providing written notice to my Provider.
- My healthcare providers may access my health information through the HIE without my consent in certain emergency situations.
- I have the right to request an audit trail of who accessed my health information through the HIE.
- I understand that the HIE has security measures in place to protect the confidentiality of my health information.

Expiration and Duration: This consent for the exchange of health information through the HIE will remain in effect until I revoke it in writing or until my healthcare providers are no longer participating in the HIE.

Patient's Consent: I have read and understand the information provided in this consent form. I voluntarily consent to the exchange of my health information through the Health Information Exchange (HIE) as described above.

INFINITE HEALTH CARE

NOTICE
Privacy Practices

Notice of Privacy Practices

This Notice of Privacy Practices explains how your medical information may be used and disclosed, as well as your rights regarding your health information under the health Insurance Portability and Accountability Act (HIPAA) and other applicable laws. "Protected Health Information" (PHI) refers to data about you, including demographic details, which may identify you and pertains to your past, present, or future physical or mental health, condition, and associated healthcare services. we recognize that your medical information is of a personal nature, and we are dedicated to safeguarding it. The records we maintain regarding the care and services you receive are essential to ensure we deliver the highest quality care while adhering to specific legal requirements. Please take a moment to review this notice carefully.

Uses and Disclosures of Health Information

Treatment: We may use your health information to provide, coordinate, or manage your medica care and treatment. This may include sharing your information with healthcare professionals involved in your care.

Payment: We may use and disclose your health information to bill and collect payment for the services we provide to you. This may include sharing your information with insurance companies or other third-party payers.

Health Care Operations: Your health information may be employed as needed to support our daily operations and management. This may include using information about the services you received for budgeting, financial purposes, complying with legal requirements, and participating in government-mandated reporting.

Required by Law: We may use or disclose your health information when required by lase, such a reporting certain diseases to public health authorities.

Legal Proceedings: Your health information may be disclosed in response to a court order, subpoena, or other legal process.

Worker's Compensation: We may disclose your health information as necessary to comply with worker's compensation laws.

INFINITE HEALTH CARE

NOTICE
Privacy Practices

Public Health Reporting: We may disclose your health information to public health agencies as mandated by law. For example, certain communicable diseases must be reported to the state's public health department in accordance with legal requirements.

Appointment Reminders: We may contact you to remind you of upcoming appointments, tests, or follow-up care.

Other Uses and Disclosures Requiring Your Authorization: Any disclosure or use of your health information for purposes not mentioned above necessitates your explicit written authorization. If you later change your mind after granting authorization for the use or disclosure of your information, you may submit a written revocation of the authorization. Note that our decision to revoke the authorization will not impact or reverse any prior use or disclosure of your information that occurred before we received notice of your decision.

Our Responsibilities

- We are legally obligated to uphold the confidentiality of your protected health information and furnish you with this notice regarding privacy practices. We are also obligated to adhere to the privacy policies and procedures specified in this notice.
- In accordance with applicable laws, we retain the authority to revise or adjust our privacy policies and procedures. These modifications in our policies and practices will be applicable to all protected health information under our custody and will be accessible at our facility upon your request.
- In compliance with federal regulations, we require that requests for the inspection or copying of protected health information be submitted in writing.

Your Rights Regarding Your Health Information

- Right to Request Amendments: If you believe that your health information is incorrect or incomplete, you have the right to request corrections or amendments.
- Right to an Accounting of Disclosures: You can request a list of the disclosures we have made of your health information.
- Right to Request Restrictions: You have the right to request restrictions on how your health information is used and disclosed.
- Right to Request Confidential Communications: You can request that we communicate with you in a specific manner or at a specific location.
- Right to a Paper Copy: You have the right to request a paper copy of this Notice of Privacy Practices.

Complaints

If you have any questions or concerns about this Notice of Privacy Practices or our privacy practices, please contact the office.

INFINITE HEALTH CARE

CONSENT
Privacy Practices

Acknowledge Receipt of Notice of Privacy Practices

Our Privacy Practices Notification offers details on how we might utilize and share your protected health information (PHI). This notice includes a section outlining your patient rights as per the law. You possess the right to request restrictions on how we use or disclose your PHI.

By signing our Privacy Practices Notification document, you grant your consent for us to utilize and disclose your protected health information for the purposes of treatment, payment, and healthcare operations. Your signature also confirms that you have received a copy of our Privacy Practices Notification.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient

INFINITE HEALTH CARE

KNOWLEDGE

Patient Bill of Rights

Bill of Rights

At Infinite Health Care, we are committed to providing high-quality healthcare services while respecting the rights and dignity of our patients. We believe that every patient deserves to be treated with compassion, respect, and fairness. To ensure that your rights as a patient are protected, we have established the following Patient Bill of Rights:

Respect and Dignity: You have the right to be treated with respect, courtesy, and consideration at all times, regardless of your age, race, gender, religion, national origin, sexual orientation, or any other characteristics.

Privacy and Confidentiality: Your medical information will be kept confidential and will not be disclosed without your written consent, except as required by law. You have the right to review and request a copy of your medical records.

Informed Consent: You have the right to be informed about your medical condition, treatment options, potential risks, and expected outcomes. You can make decisions about your care after understanding all relevant information.

Quality of Care: You have the right to receive the highest quality of medical care that is available, provided by competent and qualified healthcare professionals.

Access to Information: You have the right to access information about your diagnosis, treatment plan, and the names and credentials of your healthcare providers.

Participation in Care Decisions: You have the right to actively participate in your healthcare decisions. This includes the right to refuse treatment, except as otherwise required by law.

Pain Management: You have the right to appropriate pain management and the opportunity to discuss and receive information about pain relief options.

Consent for Research and Clinical Trials: If applicable, you have the right to be informed about and provide informed consent for participation in any research or clinical trials involving your care.

Access to Emergency Care: You have the right to access emergency medical care when necessary, regardless of your ability to pay or insurance status.

Non-Discrimination: You have the right to receive care without discrimination, and we will not discriminate against you in the provision of healthcare services.

Complaints and Grievances: You have the right to voice complaints or concerns about your care without fear of retaliation. We are committed to addressing your concerns promptly and fairly.

INFINITE HEALTH CARE

KNOWLEDGE

Patient Bill of Rights

Advance Directives: You have the right to create and provide advance directives for your medical care, and we will respect your wishes in accordance with the law.

Cultural and Religious Beliefs: Your cultural and religious beliefs will be respected to the extent possible in the provision of care.

Accessibility: We will strive to make our facilities and services accessible to individuals with disabilities in accordance with applicable laws and regulations.

Financial Transparency: You have the right to receive an explanation of your bill for services, and we will provide information on any charges that may not be covered by insurance.

By receiving care at Infinitie Health Care, you acknowledge and accept these rights. We are dedicated to upholding these principles and ensuring that you receive the highest standard of care and respect during your medical treatment.

If you have any questions or concerns about your rights as a patient or the care you are receiving, please do not hesitate to contact Loren MacDonald, Medical Director for Infinite Health Care.

INFINITE HEALTH CARE

FINANCIAL
Financial Responsibility

I, _____, the undersigned patient or legal guardian, hereby acknowledge and accept financial responsibility for all charges associated with the medical services provided to me or the patient named above by Infinite Health Care, PLLC. hereinafter referred to as "the Provider". This agreement outlines the financial responsibilities, billing procedures, and insurance matters related to the medical services.

Insurance Information: I understand that it is my responsibility to provide accurate and up-to-date insurance information to the Provider. This includes the insurance company name, policy number, group number, and any other necessary information. I am aware that insurance coverage varies, and I am responsible for understanding my coverage and any applicable deductibles, co-payments, and out-of-pocket expenses.

Payment Obligations: I understand that I am responsible for all charges incurred for the medical services provided, whether or not they are covered by insurance. This includes, but is not limited to, co-payments, deductibles, non-covered services, and any charges exceeding the liits of my insurance policy. I agree to pay all such charges promptly.

Payment Methods: I agree to make payments for services rendered by the Provider using the following payments:

- Cash
- Check
- Credit Card
- Debit Card
- Venmo
- Zelle

Billing Procedures: I acknowledge that I will receive statements from the Provider outlining the services provided and the corresponding charges. It is my responsibility to review these statements for accuracy and promptly notify the Provider of any discrepancies.

Payment Due Date: Payment for all outstanding balances is due within 30 days of receiving a statement. Failure to make timely payments may result in additional charges, including interest and collection fees.

Collection Costs: In the event that my account becomes past due and requires the involvement of a collection agency or legal action, I agree to pay all associated collection costs, including but not limited to attorney's fees and court costs.

INFINITE HEALTH CARE

FINANCIAL

Financial Responsibility

Financial Assistance: I understand that the Provider may offer financial assistance or payment plan options for patients facing financial hardship. I will contact the Provider to discuss these options if needed.

Changes in Insurance Coverage: I agree to promptly inform the Provider of any changes in my insurance coverage, including changes in policy, coverage termination, or a change in the primary insurance holder.

Authorization for Release of Information: I authorize the Provider to release any necessary medical information to my insurance company for the purpose of processing claims.

Acknowledgement of Financial Responsibilities

I have read and understand the terms and conditions outlined in this Financial Responsibility Form. I accept full responsibility for payment of all charges associated with the medical services provided by the Provider.

_____ _____

Signature of Patient or Patient's Representative | Date

_____ _____

Printed Name | Representative's Relationship to Patient

INFINITE HEALTH CARE

KNOWLEDGE

No-Show, Late & Cancellation Policy

Description: "No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at their appointment 15 minutes after the expected arrival time for their scheduled appointment.

Policy: It is the policy of this practice to monitor and manage appointment no-shows and late cancellations. Our goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt care.

Procedure:

- A patient is notified of the appointment "No-Show, Late & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

1. Established Patients:
   a. Appointment must be canceled at least 24 hours prior to the scheduled appointment time. If the appointment is not canceled at least 24 hours prior to the scheduled appointment, a $50 fee will be due upon arrival of the next appointment.
   b. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future visit, if available. If appointments are not yet available for their provider, a reminder will be placed for the patient to call to make a future appointment once the schedule opens.
   c. In the event a patient has incurred three (3) document3ed "no-shows" and/or "same-day cancellations", the patient may be subject to dismissal and will no longer be able to utilize our services.
2. New Patients:
   a. Scheduled appointments must be canceled at least 24 hours prior to the appointment time. If the appointment is not canceled at least 24 hours prior to the scheduled appointment, a $150 fee will be due upon arrival of the next appointment.
   b. In the event a patient arrives late as defined by "late arrival" to their appointment, our office reserves the right to request a new referral sent from the referring Provider.
   c. In the event of three (3) documented "same-day cancellations," the patient may be subject to dismissal from our services.

Signature of Patient or Patient's Representative

Date

Printed Name

Representative's Relationship to Patient

INFINITE HEALTH CARE

DIRECTIVES

Advanced Directive Form

Advanced Directive

I, _____, being of sound mind and legal capacity, hereby execute this Advanced Directive to provide guidance regarding my medical treatment preferences in the event that I am unable to make decisions for myself.

Full Name (Print) | Signature | Date of Birth

Address | City, State, Zip | Date Signed

I appoint _____, as my primary healthcare agent to make all healthcare and medical decisions on my behalf, if I am unable to do so. If my designated primary healthcare agent is unable or unwilling to act on my behalf, I appoint _____, as my secondary healthcare agent.

Primary Name (printed) | Primary Signature | Date Signed

Address | Relationship to patient | Phone Number

Secondary Name (printed) | Secondary Signature | Date Signed

Address | Relationship to patient | Phone Number

INFINITE HEALTH CARE

CODE STATUS

Declaration of Desires

When Agents Authority Becomes Effective

My agent's authority becomes effective when my primary Provider determines that I am unable to make my own health care decisions.

Agent's Obligations

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my persona values to the extent know to my agent.

DECLARATION OF DESIRES: I express my desires regarding medical treatment as follows:

A. Life-sustaining Treatment:

☐ I request that all medically available means be used to prolong my life, including but not limited to, artificial respiration, artificial nutrition, and hydration.

OR

☐ I do not want my life to be artificially prolonged, and I request that only treatment necessary for my comfort be provided.

B. DO-NO-RESUSCITATE (DNR) ORDER:

☐ I request that no cardiopulmonary resuscitation (CPR) or other resuscitative measures be used if my heart or breathing stops.

OR

☐ I do no have a DNR/DNI order and wish for CPR and resuscitative measures to be used.

C. Organ Donation:

☐ I wish to donate my organs for transplatation or medical research, as specified in a sperate organ donation document or as allowed by applicable laws.

Pallative Care and Comfort Measures:

☐ I request palliative care to manager pain and provide comfort in the event of a terminal illness or irreversible condition.

Specific Medical Treatment Instructions and Preferences: Please include any specific medical treatment instructions or preferences you may have, such as religious or cultural considerations, pain management, or other medical procedures not mentioned above.

Signature of Patient	Date	Witness	Date

INFINITE HEALTH CARE

CONSENT
Advanced Directive

Advance Care Planning Discussion

I have discussed my advanced directive and medical preferences with my healthcare agent, family members, and healthcare providers. I declare that I am signing this Advanced Directive willingly and without any coercion. I have read and understood its contents, and I am aware of the consequences of my choices.

Print Name	Signature	Date

Statement of Witness

I declare under penalty of perjury that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence. That the individual signed or acknowledged this advance directive in my presence. That the individual appears to be of sound mind and under no duress, fraud, or undue influence.

WITNESS #1:

Print Name	Signature	Date

WITNESS #2

Print Name	Signature	Date

INFINITE HEALTH CARE

CONSENT

Consent to Disclose Health Care Information