New Patient Information

Patient's Name:	Gender (Check one): o Male o Female o Transgendered (Specify):_____	Date of Birth:	Social Security no.:
Street Address:	City and State:	Zip Code:	Home Phone:
Cell Phone:	Email:		
Marital Status (Check one): o Single o Married o Widowed o Divorced o Separated	Race (Check one): o White o Black/African American o American Indian/Alaska Native o Asian o Native Hawaiian/Other Pacific Islander o Other _____ o Declined		Ethnicity (Check one): o Hispanic/Latino o Not Hispanic/Latino o Declined
Patient's Employer:	Occupation (indicate if student):	Business Phone:	

IF PATIENT IS UNDER THE AGE OF 21

Parent/Guardian Name:	Street Address, State and Zip Code:	Date of Birth:
Home Phone:	Cell Phone:	Relationship to Patient:
Parent/Guardian's Employer:	Occupation:	Business Phone:
Additional Parent/Guardian Name:	Street Address, State and Zip Code:	Date of Birth:
Home Phone:	Cell Phone:	Relationship to Patient:
Additional Parent/Guardian's Employer:	Occupation:	Business Phone:

INSURANCE INFORMATION

Person responsible for payment, if not above:	Street Address, State and Zip Code:	Home Phone:

Insurance:	ID #	Group#
Medicare: If you have a Managed Medicare product as your primary insurance, we also need your Medicare Issued ID#	Medicare ID #	
Secondary Insurance:	ID #	Group#
Primary Insurance Holder Name (If different than patient):	Primary Insurance Holder Date of Birth (If different than patient):	
Additional Comments:		

Do you have a Health Care Proxy?	Yes	No

Patient DOB:_____ For Office Use: Chart Number: _____

Medical History

Reason for visit:	When was your last Preventive Exam:	Previous Primary Care Provider:

Childhood Illness (Select all that apply):	Immunizations (Select all that apply):
o Measles o Mumps o Rubella o Chickenpox o Rheumatic Fever o Polio	o Tetanus o Hepatitis o Influenza o Pneumonia o Chickenpox o MMR (Measles, Mumps, Rubella)

Recent Changes

Please mark if you have had any recent changes in the following items, and provide a brief description

Weight	Yes	No	Explain:
Energy Level	Yes	No	Explain:
Ability to Sleep	Yes	No	Explain:
Other Pain or Discomfort?	Yes	No	Explain:
Do you feel depressed?	Yes	No	

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a **blood transfusion (Circle one)**? Yes No

Other Health Problems

Please mark if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain

Skin:	Yes	No	Explain:	Female Organs:	Yes	No	Explain:
Ear, Nose, Throat:	Yes	No	Explain:	Male Organs:	Yes	No	Explain:
Heart:	Yes	No	Explain:	Bones, Joints:	Yes	No	Explain:
Lung:	Yes	No	Explain:	Brain, Spinal Cord, Back:	Yes	No	Explain:
Stomach, Intestine:	Yes	No	Explain:	Endocrine (Thyroid, Diabetes):	Yes	No	Explain:
Kidney, Bladder:	Yes	No	Explain:	Mental Health:	Yes	No	Explain:

Patient DOB:_____ For Office Use: Chart Number: _____

Medications **Please list all of your prescribed medications, including over-the-counter medications such as vitamins and inhalers**		
Name of Medication	Strength	Dosage/Frequency

Please list any **ALLERGIES TO MEDICATIONS:**

Name of Medication	Reaction

Allergies **Please list any known Allergies**	
1.	2.
3.	4.
5.	6.

Family Health History					
Relationship	**Age**	**Significant Health Problems**	**Relationship**	**Age**	**Significant Health Problems**
Mother			Child o Male o Female		
Father			Child o Male o Female		
Sibling o Male o Female			Grandmother (Maternal)		
Sibling o Male o Female			Grandfather (Maternal)		
Sibling o Male o Female			Grandmother (Paternal)		
Sibling o Male o Female			Grandfather (Paternal)		

Patient DOB:_____ For Office Use: Chart Number: _____

Health Habits & Personal Safety

All questions contained in this questionnaire are optional and will be kept strictly confidential

<table>
<tr><td>Exercise</td><td colspan="2">o Sedentary (no exercise)
o Mild Exercise (i.e., climb stairs, walk 3 blocks)
o Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week)
o Regular Vigorous Exercise (i.e., work or recreation, 4x/week)</td><td>Diet</td><td>Rank your Salt Intake
o High
o Medium
o Low</td><td>Rank your Fat Intake
o High
o Medium
o Low</td></tr>
<tr><td>Caffeine</td><td colspan="2">None
Coffee
Tea
Soda
Number of Cups/Cans per day? _____</td><td>Alcohol</td><td colspan="2">Do you drink alcohol?
o Yes
o No

If Yes, what kind? _____
How many drinks per week? _____</td></tr>
<tr><td>Tobacco</td><td>Do you use tobacco?
o Yes
o No</td><td>If Yes, what do you use?
o Cigarettes (pks/day) _____
o Chew (#/day) _____
o Pipe (#/day) _____
o Cigars (#/day) _____</td><td>Drugs</td><td colspan="2">Do you currently use recreational street drugs?
o Yes
o No

Have you ever given yourself street drugs with a needle?
o Yes
o No</td></tr>
<tr><td>Sexual Activity</td><td colspan="2">Are you sexually active?
o Yes
o No
If YES, are you trying for a pregnancy?
o Yes
o No

If not trying for pregnancy, list the contraceptive or barrier method used:_____</td><td>Do you experience any discomfort during intercourse?
o Yes
o No</td><td colspan="2">Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and intravenous drug use and unprotected sexual intercourse.

Would you like to speak with your provider about your risk of this illness?
o Yes
o No</td></tr>
<tr><td>Personal Safety</td><td colspan="2">Do you live alone?
o Yes
o No
Do you have frequent falls?
o Yes
o No
Do you have vision or hearing loss?
o Yes
o No</td><td colspan="3">Do you have an Advance Directive and/or Living Will?
o Yes
o No
Would you like information on the preparation of these?
o Yes
o No
Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse.
Would you like to discuss this issue with your provider?
o Yes
o No</td></tr>
</table>

Patient DOB:_____ For Office Use: Chart Number: _____

Women's Health Only		
Age at onset of menstruation:	Date of last menstruation:	How many days between periods?
	Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? o Yes o No	Do you have heavy periods, irregularity, spotting, pain, or discharge? o Yes o No
Number of Pregnancies:	Number of live births:	Are you pregnant or breast feeding? o Yes o No
Have you had a D&C, hysterectomy, or Caesarean? o Yes o No	Any urinary tract, bladder, or kidney infections with the last year? o Yes o No	Any blood in your urine? o Yes o No
Any problems with control of urination? o Yes o No	Any hot flashes or sweating at night? o Yes o No	Have you experienced any recent breast tenderness, lumps, or nipple discharge? o Yes o No
What is the date of your last PAP and rectal exam? _____		

Men's Health Only		
Do you usually get up to urinate during the night? o Yes o No If YES, how many times/night? _____	Do you feel pain or burning when you urinate? o Yes o No	Is there any blood in your urine? o Yes o No
Do you feel burning discharge from your penis? o Yes o No	Has the force of your urination decreased? o Yes o No	Have you had any kidney, bladder, or prostate infections within the last 12 months? o Yes o No
Do you have any problems emptying your bladder completely? o Yes o No	Any difficulty with erection or ejaculation? o Yes o No	Any testicle pain or swelling? o Yes o No
What was the date of your last prostate and rectal exam? _____		

Family Medicine Associates

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.
If you have any questions about this Notice please contact:
Privacy Official (Phone 607-277-4341)

I. Our commitment to Protecting Health Information About You:

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

II. How We May Use and Disclose Protected Health Information (PHI) About You:

Uses and Disclosures of HPI for Treatment, Payment, and Health Care Operations.
We may use and disclose PHI for treatment, payment, or health care operations. The examples included with each category do not list every type of use or disclosure that may fall within that category.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We may consult with other health care providers regarding your treatment and coordinate or manage your health care with others. For example, we may use and disclose PHI when you need a prescription, lab work, an x-ray or other health care services.
Payment: We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. For example, we may ask for payment approval from your health plan before we provide care or services. We may use and disclose PHI for billing, claims management and collection activities. We may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.
Healthcare Operations: We may use or disclose PHI in order to support the business activities of your physician's practice. Health care operations include doing things that allow us to improve the quality of care we provide and to reduce health care costs. We may use and disclose PHI about you in the following health care operations:

- Reviewing and improving the quality, efficiency and cost of care that we provide our patients.
- We may use PHI to identify groups of people with similar health problems to find them information about treatment alternatives and educational classes.
- We may call you by name in the waiting room when your physician is ready to see you.
- We may disclose your PHI to students in various medical programs involved with the practice.
- We may use or disclose your PHI, as necessary, to contact you by mail or by phone to remind you of your appointment. We may leave a message on your answering machine.

We will share your PHI with third party "business associates" that perform various activities for the practice. Whenever an arrangement between our office and a business associate involved the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Family Medicine Associates

Notice of Privacy Practices

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician has taken an action in reliance on the use or disclosure indicated in the authorization.

Uses and Disclosures For Which You Have The Opportunity To Agree or Object.
We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: We may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individual involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your PHI if your physician attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object.
We may use or disclose your PHI in the following situations without your consent or authorization.

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your PHI to public health authorities. The disclosure may be made:

- To prevent or control disease, injury or disability
- To report disease, injury, birth or death
- To report child abuse or neglect
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities.
- To notify a person who may have been exposed to a communicable disease.
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illnesses, or workplace medical surveillance.
- We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose PHI to a public health authority that is authorized by law to receive reports of domestic violence, abuse or neglect.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.
Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
Required Uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

III.Your Rights

Under federal law, you have the following rights regarding PHI about you.
You have the right to inspect and copy your protected health information. You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. This includes your medical and billing records but does not include information gathered or prepared for a civil, criminal or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. To inspect and coy PHI, please contact our Privacy Official.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. To request restrictions, you must make your request in writing to our Privacy Official.

You have the right to request to receive confidential communications. You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. We will accommodate reasonable requests. You must make your request in writing to our Privacy Official. You must specify how you would like to be contacted. We may also condition this accommodation by asking you for information as to how payment will be handled.

You may have the right to have your physician amend your PHI. You may request an amendment of PHI about you as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Official if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, or to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. If you wish to make such a request, please contact the Privacy Official.

You have the right to receive notification of unauthorized disclosure of your PHI (Breach Notification) We are required to notify you upon a breach of any unsecured PHI. The notice must be made without reasonable delay, but no later than 60 days from when we discover the breach.

You have the right to obtain a paper copy of this notice from us, upon request, at any time.

IV.Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

For further information about the complaint process you may contact:
Privacy Official
(607) 277-4341
Family Medicine Associates; 209 West State Street, Ithaca, NY 14850

This notice was published and became effective on April 14, 2003.
Revised: 4/7/17

Health Care Proxy

Appointing Your Health Care Agent in New York State

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

About the Health Care Proxy Form

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

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

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

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

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

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

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

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

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

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

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

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

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

Frequently Asked Questions

Why should I choose a health care agent?

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

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

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

Who can be a health care agent?

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

How do I appoint a health care agent?

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

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

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

What decisions can my health care agent make?

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

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

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

How will my health care agent make decisions?

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

How will my health care agent know my wishes?

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

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

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

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

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

Who will pay attention to my agent?

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

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

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

What if I change my mind?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Care Proxy Form Instructions

Item (1)

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

Item (2)

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

Item (3)

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

Item (4)

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

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

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

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

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

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

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

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

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

Item (5)

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

Item (6)

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

Item (7)

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

Health Care Proxy

(1) I, _____

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

_____

_____

*as my health care agent to make any and all health care de*cisions 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 and/or Tissue Donation

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

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

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

Your Signature _____ Date _____

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

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

Date _____ Date _____

Name of Witness 1
(print) _____

Name of Witness 2
(print) _____

Signature _____ Signature _____

Address _____ Address _____

_____ _____

NEW YORK STATE | Department of Health