CareFront Medical Group

Physician: Lajja Patel, MD

Patient Registration Information

Name: (Last,First,Middle) _____,_____,_____

Date of Birth: ____/_____/_____ SSN#_____-_____-_____ Sex: M / F

Contact Info: Primary #: (____) _____-_____ Secondary #: (____) _____-_____

Email: _____@_____

Address: _____City_____St.____Zip_____

Preferred Language: _____ Race: _____

Name of Employer: _____ Job Title:

_____

Emergency Contact:

Name: _____ Relation: _____

Phone #: _____

Address: _____ City _____ St.____ Zip_____

Insurance Information:

Plan Name: Primary _____ Secondary _____

Member ID #: Primary _____ Secondary _____

Health History:

Childhood Illness:

☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

☐ Other: _____

Immunization/Vaccination:

☐ Tetanus (___/___/_____)

☐ Hepatitis (___/___/_____)

☐ Influenza (___/___/_____)

☐ Pneumonia (___/___/_____)

☐ Chickenpox (___/___/_____)

☐ MMR (Measles, Mumps, Rubella) (___/___/_____)

Surgical History:

Procedure: _____ Year: _____ Location: _____
Procedure: _____ Year: _____ Location: _____
Procedure: _____ Year: _____ Location: _____
Procedure: _____ Year: _____ Location: _____

Are you currently or ever been diagnosed with any of the following?

- ☐ Amputation(s)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Back / Neck Pain
- ☐ Bladder Incontinence
- ☐ Bowel Disease
- ☐ CAD
- ☐ Cancer(s) _____
- ☐ Cataracts
- ☐ Colitis or Diverticulosis
- ☐ Congestive Heart Failure
- ☐ COPD or Emphysema
- ☐ Dementia or Memory Loss
- ☐ Depression and/or Anxiety
- ☐ Diabetes (Type 1 / Type 2)
- ☐ Endocrine Disease
- ☐ Eye Problems
- ☐ Gastritis / Ulcer
- ☐ GERD / Acid Reflux
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Hearing Loss / Ear Problems
- ☐ Heart Disease
- ☐ Heart Rhythm Disorder
- ☐ Hemorrhoids
- ☐ HBP (High Blood Pressure)
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Illness
- ☐ Movement Disorder
- ☐ Nerve Disease
- ☐ Osteopenia / Osteoporosis
- ☐ Overweight / Obesity
- ☐ Pneumonia
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stomach / Duodenal Ulcer
- ☐ Stroke / TIA
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Urinary Problem(s)
- ☐ Viral Disease

- ☐ Other: _____

Health Habits:

Tabacco Use: (Y / N) Currently: (Y / N) Previously: How long? _____
☐ Cigarettes: ____/Day ☐ Chew: ____/Day ☐ Cigars: ____Day

Caffeine: ☐ None ☐ Occasional ☐ Moderate ☐ Regularly: _____/Day

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Drugs: Do you currently use recreational or illicit drugs? (Y / N)

Alcohol: (Y / N) _____/Week

Exercise: ☐ Not at all ☐ Mild ☐ Occasional ☐ Regularly

Diet: (Y / N) Prescribed by physician? (Y / N) Number or Meals: _____/Day
Salt Intake: ☐ High ☐ Med ☐ Low Fat Intake: ☐ High ☐ Med ☐ Low

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WOMEN ONLY:
Last PAP Smear Date: _____
Last Mammogram Date: _____
Last Menstrual Period: _____ OR Menopause Start Date: _____
Currently Pregnant: (Y / N) Breastfeeding: (Y / N) Possibility of being pregnant? (Y / N)
Have you had the following: ☐ D&C (Y / N) ☐ Hysterectomy (Y / N) ☐ Cesarean (Y / N)
Any urinary tract, bladder, or kidney infection(s) with in the last year? (Y / N)
Blood in urine? (Y / N)
Problems controlling urine? (Y / N)
Hot flashes or sweating at night? (Y / N)

MEN ONLY:
Do you get up in middle of night to urinate? (Y / N) _____/Per night
Feel a burning while urinating? (Y / N)
Blood in urine? (Y / N)
Do you feel discharge from penis? (Y / N)
Has force of urine decreased? (Y / N)
Any bladder, kidney or prostate infection(s) with in the last year? (Y / N)
Problems emptying bladder completely? (Y / N)
Testicular pain or swelling? (Y / N)
Difficulty with erection or ejaculation? (Y / N)
Last Prostate Exam Date: _____

Family Health History:

Family Member: _____ Diagnosis: _____ Age of DX: _____
Family Member: _____ Diagnosis: _____ Age of DX: _____
Family Member: _____ Diagnosis: _____ Age of DX: _____
Family Member: _____ Diagnosis: _____ Age of DX: _____
Family Member: _____ Diagnosis: _____ Age of DX: _____
Family Member: _____ Diagnosis: _____ Age of DX: _____

Notes:

CareFront Medical Group

Financial Policy:

We are happy that you have selected CareFront Medical Group, PLLC for your healthcare needs and look forward to working with you. To better help you understand your financial responsibilities as a patient in relations to your medical care, we would like to outline such financial policies.

Patients are expected to provide identification and if insure, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for such services at the time of services. This includes any past due balance from prior dates of service. Retuned checks will be subject to fees.

Medicare Patients: The office will bill the Medicare intermediary. Patients are responsible for following: Annual Medicare deductible, all applicable co-pays of allowed charge, any non-covered services, any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed and "Advanced Beneficiary Notice" (ABN).

Medicare Supplemental and Secondary Insurances: The practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payments of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of services as well as for any changes for which the patients failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the practice. Patients are responsible for the balance in full if not paid by the insurance in 30 days. If the patient is not finically prepared to pay co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to be seen my physician or nurse practitioner. If patients condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Out of State Insurance: If patient presents with an out of state HMO/PPO insurance card(s), we will need to verify the patients benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co0insurance or deductible.

CareFront Medical Group

Financial Policy Continued:

Assignment and release: I hereby assign my insurance or other third-party carrier benefits to be paid directly to the physician practice, realizing I am responsible for any resulting balance. I also authorize the physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that o a, financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

Electronic check Conversion: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account to process the payment as a check transaction. When we use information form your check to make an electronic fund transfer, funds may be withdrawn from account the same day.

Patient Signature: _____

Printed Name: _____

Date: _____

CareFront Medical Group

Medicine

Name:	Direction:	Days:	Qty:

Allergies:

Name:	Reaction:

Pharmacy:

Name:	Address:

Patient Sign: _____ Staff Sign: _____

CareFront Medical Group

HIPAA Compliance Patient Consent Form:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing consent.

The terms of notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. HIPAA (Health Insurance Portability Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not agree to those restrictions.
- The patient has the right to revoke this consent in wiring at any time and full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments? ☐ YES☐NO

May we leave a message on your answering machine at home or on your cell? ☐YES☐NO

May we discuss your medical condition with members of you family?☐YES☐NO
If YES, please name such family member allowed:
Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

This consent was signed by: _____
(PRINT NAME)

Signature: _____ Date: _____
Witness: _____ Date: _____

CareFront Medical Group

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my personal medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release is as follows:

Complete Records	History & Physical	Progress Notes
Care Plan	Lab Reports	Radiology Reports
Pathology Reports	Treatment Record	Operative Reports
Hospital Reports	Medication Record	Other (please specify below)

_____

Release my protected health information to the following physician/person/facility/entity and/ or those directly associated with my medical care:

Name: CareFront Medical Group,
Address: 10423 State Highway 151, Suite. 103
City, State, Zip Code: San Antonio, Texas 78251
Fax: 210-876-1761
Phone: 210-876-1451

Patient Signature: _____

Patient Printed Name: _____

Date: _____

CareFront Medical Group

No Call No Show Policy

We schedule our appointments to ensure each patient receives the ample allotted amount of time to be seen by our physicians and medical staff. It is very important to honor your scheduled appointment time with us and arrive promptly.

If your schedule changes and you are unable to keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to receive their needed medical care, please give us at least 24-hour notice.

If you do not cancel or reschedule your appointment with at least 24-hour notice, we may assess a **$25.00 fee** to your account. This "no-show fee" will not be reimbursable by your insurance company. You will be billed directly and held responsible for such balance.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

CareFront Medical group & MedCede Physician Services

I understand the "no-show" policy of CareFront Medical Group/MedCede Physicians and agree to provide a credit card number, which may be charged $25.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge to the payment method provided.

Patient Signature: _____

Patient Name: _____

Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks,* how often have you been bothered by any of the following problems?

(Please select your answer between 0-3)

	Not at all	Several Days	More than Half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have teen moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself	☐ 0	☐ 1	☐ 2	☐ 3
Add Columns				
TOTAL				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all Sure	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as ifsomething awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
Total Score (add your column scores) =				

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

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

CAREFRONT MEDICAL GROUP

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE AND MOOD OR MIND ALTERING PRESCRIPTIONS

Controlled substances and mood or mind altering medications (i.e. narcotics, tranquilizers, benzodiazepines, ADHD medication, sleep aids, antidepressants, barbiturates and any mood or mind altering medication) are very useful for controlling acute pain, chronic pain and other conditions but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain and other conditions, thus improving quality of life, function and/or ability to work. Because my physician is prescribing a controlled substance or mood or mild altering medication to help manage my condition, I agree to the following condition.

PATIENTS' RESPONSIBILITY

- I am responsible for the medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it **will not be replaced.**
- I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposes of maintaining accountability. This includes a copy of this contract.
- I will use **only one pharmacy** for all my prescription refills. I will register the name and phone number of this pharmacy with my physician.
- I understand that driving a motor vehicle may not e allowed while taking my medications and that it is my responsibility to comply with the laws of Texas while taking the prescribed medications.
- At any time while I am receiving medications, it may be deemed necessary by my doctor that I see a medication-use specialist. I understand that if I do not attend such an appointment, my medications will be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence's (addiction); my medications may be tampered to completion.
- I agree to undergo random and scheduled urine drug testing at the discretion of the provider. The test will show the presence of my prescript medication but will also show any illicit drugs. The presence of my prescribed medication and any illicit drugs. The presence of illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breech of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered rounds for dismissal.
- I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medication from Dr. Patel without her permission. I will not give, share or sell my medications to any other person.

REFILLS OF MEDICATIONS

- Will be made only during regular office hours Wednesday through Saturday, in person. This will be done either monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays.

- Will not be made ifI ‘‘run out early,’’ or ‘‘lose a prescription,’’ or spill or ‘‘misplace my medication,’’ of ‘‘they are stolen.’’ I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid their theft.

- Will not be made as an ‘‘emergency’’ such as on Friday afternoon because I suddenly realize I will ‘‘run out tomorrow.’’ I will call at least 24 hours in advance to schedule an appointment for refills.

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated immediately, without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. I am ; responsible for any withdrawal syndrome that may occur to do my misuse of the narcotic medication and/or termination of my care.

I have read this contract and the same has been explained to me by Dr. Patel or NP Helena Hartmann. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequence of violating this agreement.

Date_____ Patient_____ Witness_____

Copy given to pt. Date:_____ Pt refused copy. Date:_____

CareFront Medical Group

Urine Drug Testing Protocol

Our staff at CareFront Medical Group, PLLC is committed to providing effective treatments to all it's patients and patients suffering from chronic pain and other disorders. This treatment may include the use of opioid analgesics, other narcotic pain medications, scheduled drugs requiring a triplicate prescription and other mood and/or mind-altering drugs. Due to the epidemic of the abuse of prescription pain and other medication, as well as other narcotic drugs and in order to monitor and account for the patient's compliance in taking their medication as prescribed, all patients will be subject to urine drug testing.

Circumstances for Urine Drug Testing

- All new patients currently on or will be receiving any schedule ll-V class drug or mood and/or mind-altering drug will be tested at first appointment with $50 UDS for prescription to be written, along with UDS every 30 days for prescription to be continuously refilled and a confirm test every 90days.

- All existing patients with high-risk symptoms not tested In last 365 (Annual Physical date).

- All existing patients will be tested every 30 days with UDS at $50 charge, if using opioid analgesics or other narcotic pain medication. If there is a discrepancy in UDS test, we will continue with UDS every 30 days along with a confirmatory test same day and placed on compliance monitoring for 90 days. The confirmatory test will be billed to patient insurance and required for a 90day period. If patient fails any confirmatory test, prescription(s) will be discontinued.

- All existing patients will be tested every 30 days with UDS at $50 charge, if using any Schedule II medication. If there is a discrepancy in UDS test, we will continue with UDS every 30 days along with a confirmatory test same day and placed on compliance monitoring for 90 days. The confirmatory test will be billed to patient insurance and required for a 90day period. If patient fails any confirmatory test, prescription(s) will be discontinued.

- All existing patients will be tested every 30 days with UDS at $50 charge, if using any other Schedule lll-IV or mood and/or mind-altering drug that does not fall under 3 or 4 from above. If there is a discrepancy In UDS test, we will continue with UDS every 30 days along with a confirmatory test same day and placed on compliance monitoring for 90 days. The confirmatory test will be billed to patient insurance and required for a 90day period. If patient fails any confirmatory test, prescription(s) will be discontinued.

- High Risk Patients - Patients will be tested every 30 days with UDS and confirmatory testing if considered high-risk (patients who has admitted to a substance abuse problem and is on any scheduled drug or mood and/or mind altering drug or any patient currently on a mood or mind altering drug schedule ll-IV who has tested positive for a drug not prescribed or illicit drug) for a period of90 days, until patient has demonstrated proper compliance during such period. Positive illicit drug results on either test during the 90day period, will result in discontinuation of prescription(s).

Patient Signature:_____Date:_____

Provider Signature:_____ Date:_____

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Advance Directives Act (see §166.033, Health and Safety Code)

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

DIRECTIVE

I,_____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

I request that all treatments other than those needed to keep me comfortable be discontinued or withheld land my physician allow me to die as gently as possible; OR

I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make health care or treatment decisions with my physician compatible with my personal values:

1 ._____

2. _____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use ofall available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect ifI have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed _____ Date_____

City, County, State of Residence_____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness 1 may not be a person designated to make a health care or treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee o fa health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee o fa health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 Witness 2

Definitions: "Artificially administered nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the gastrointestinal tract.

"Irreversible condition" means a condition, injury, or illness:
that may be treated, but is never cured or eliminated;
that leaves a person unable to care for or make decisions for the person's own self; and
that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.