Jose M Pavia, MD, Inc.
13768 Roswell Ave, Suite 101
Chino, CA 91710

Advance Directive Acknowledgement

1. Are you 18 or older? ☐ YES ☐ NO

2. Have you formulated an Advance Directive? ☐ YES ☐ NO

3. I am aware that Advanced Directives may be any one of the following:

    a) Durable Power of Attorney for Health Care.

    b) California Natural Death Act-Ex. A Living Will.

    c) Living Health Care Will.

    d) I may write down my wishes on a piece of paper so that my family may use the document, in deciding my medical treatment, in the event I am unable to do so.

4. If you have formulated an Advance Directive, you hereby agree to furnish **Jose M. Pavia, M.D., Inc.** with a copy within_____days.

5. If you change, amend, alter or cancel your Advance Directive, you hereby agree to notify our office and provide us with a copy as soon as possible so that **Dr. Pavia** will be able to comply with your wishes.

6. Expiration date of Advance Directive, if any_____

    (If the Advance Directive was formulated before 1991, it is "good" for only seven years, Advance Directives formulated after 1991, as "good" indefinitely, unless you change/amend/cancel the Advance Directive.)

7. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide **Dr. Pavia** with any documents that are required to carry out my Advanced Directives.

This is an acknowledgement that Dr. Pavia, or one of his staff members, has provided me information concerning Advanced Directives.

_____ _____
Signature Date

_____
Print Name

If not signed by the patient, please indicate relationship:

☐ **Parent or guardian of minor patient** ☐ **Guardian or conservator of an incompetent patient**

_____
Print Name of Patient and Date of Birth

This document will become part of my medical record.