



6449 38th Avenue North
Suite F4
St. Petersburg, FL 33710

Faña Medical Group, P.A.

(727) 384-0192
Fax (727)384-1500
Office Hours: Mon. - Fir. 8 - 4:30

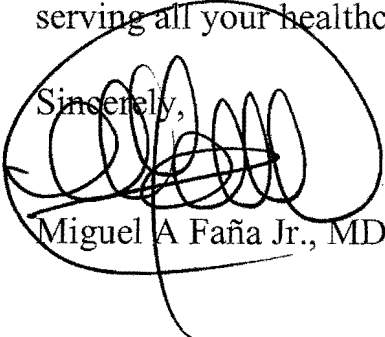
Dear Patients:

Here at Faña Medical Group we take your health very seriously. We want to take this opportunity to give you some healthful tips in order for us to provide the Best possible healthcare to you.

- In the event of any urgent healthcare needs I am available 24 hours a days. Please do not hesitate to contact me with any concerns. Calling 727-384-0192 after-hours will forward the calls to my answering service. A LIVE operator will take your message and I will call you back promptly.
- In the event of an ER visit or hospitalization, inform the staff at the ER so we can be notified. This will help us ensure you receive the care you deserve. After discharge, please call our office so we can schedule an appointment immediately.
- I have privileges in the following hospitals:
 - Bayfront Hospital
 - St Petersburg General
- Whenever you need to schedule appointments, feel free to call our office. Please remember to bring your medication bottles to the visits.
- When you have a health-related concern, feel free to call the office so we can arrange an appointment. Many times, I will want to see you that same day to avoid serious consequences to your health.

WELCOME to our practice. We look forward to keeping you healthy by serving all your healthcare needs.

Sincerely,



Miguel A Faña Jr., MD

**WELCOME TO FANA MEDICAL GROUP
DR. MIGUEL A. FANA JR.**

- Our **physicians are available 24 hours a day** for your urgent healthcare needs and will return your call. There is a live answering service that will have the doctor call you back.

**Call our main number
727-384-0192**

- **Preferred Hospitals:** Our doctors have selected the following hospitals because of their confidence in and professional rapport they have with the hospital and rounding doctor. In an emergency, notify your ambulance of your preferred hospital.

***NORTHSIDE HOSPITAL
BAYFRONT MEDICAL CENTER
ST. PETERSBURG GENERAL HOSPITAL***

- If you have an **urgent healthcare need during our normal business hours**, 8:00 am–4:30 pm Monday through Friday, we will make the necessary arrangements to **see you the same day**.
- **After a hospital stay or emergency room visit**, contact our office immediately after discharge. Your doctor will need to see you in the office to assure your continued recovery.
- **Scheduling appointments:** Call our main number to schedule your appointment and be sure to bring your medications with you to each appointment. When you schedule an appointment please remember that your doctor has personally set that time aside for you. If you are unable to keep your appointment, please call us at least 24 hours in advance so your doctor can offer that appointment to someone else with a healthcare need.
- **Preventive care:** If you are a Medicare patient, your doctor would like to see you every 6 months. This will help both you and your doctor maximize preventive care.
- **Prescription refills:** Contact your pharmacy and they will fax us the request that day for your doctor's approval. Please call at least 3 days before your medication is needed.

FANA MEDICAL GROUP

Physician Information

Miguel Fana, M.D.

Dr. Miguel Fana is Board Certified in Internal Medicine and is a Member of the American Medical Association and a Fellow of the American College of Physicians. Born and raised in Manhattan, New York, Dr. Miguel Fana received his Doctorate in Medicine in 1995.

Later he completed his residency training at New York Hospital Medical Center of Queens, where he also served as Chief Resident, Junior Teaching Attending and Emergency Room Staff Physician. He came to Tampa Bay in July 2000. For 5 years he served as Associate Medical Director for JSA Healthcare.

He began private practice as a JSA Affiliate Physician in October 2005.

Patient Medical History

Date of last physical exam: _____ Physician Name: _____

Address: _____

PAST HISTORY (Personal and Allergies):

Have you had any of the following illnesses?

| | Yes | No | | Yes | No | | Yes | No |
|------------------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol Overuse | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies (other than medications) | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Other Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Kidney or Bladder Infections | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Lung Infections | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder Disease | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Colitis | <input type="checkbox"/> | <input type="checkbox"/> | | | | Measles | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Migraine Headache | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Mumps | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Nervous Breakdown | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Sexually Transmitted Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Sickle Cell Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Stomach Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Whooping Cough | <input type="checkbox"/> | <input type="checkbox"/> |

PERSONAL HABITS:

- 1) Have you ever smoked? Yes No Have you used chewing tobacco? Yes No # of yrs _____
 If yes, are you are regular smoker now? Yes No If No, when did you quit? _____
- 2) Do you regularly drink alcohol: Yes No If yes, how often: _____
- 3) Have you ever used any of the following: Marijuana LSD Heroin Cocaine Speed Other _____

OPERATIONS: List and indicate approximate year.

SERIOUS INJURIES:

List injuries and give approximate dates.

HOSPITALIZATIONS: (Other than operations)

List reasons and approximate dates

DIAGNOSTIC TESTS/EXAMS:

| LAST TEST/EXAM | DATE | LOCATION/PROVIDER |
|----------------|-------|-------------------|
| EYE EXAM: | _____ | _____ |
| FOOT EXAM: | _____ | _____ |
| PAP SMEAR: | _____ | _____ |
| MAMMOGRAM: | _____ | _____ |

IMMUNIZATIONS: (Please give date) Hepatitis B _____ Flu _____ Polio _____

Typhoid _____ Smallpox _____ Tetanus _____ Pneumococcal _____ Chicken Pox _____

| FAMILY HISTORY | Circle Sex | | IF LIVING | | IF DECEASED | |
|------------------|------------|---|-----------|--------|--------------|-------|
| | | | AGE | HEALTH | AGE AT DEATH | CAUSE |
| Father | | | | | | |
| Mother | | | | | | |
| Brothers/Sisters | M | F | | | | |
| | M | F | | | | |
| | M | F | | | | |
| Husband/Wife | | | | | | |
| Sons/Daughters | M | F | | | | |
| | M | F | | | | |
| | M | F | | | | |

Check if any blood relative has or had any of the following and enter their relationship:

| Yes No | | Relationship to you | Yes No | | Relationship to you |
|--------------------------|---|---------------------|---------------------|---|---------------------|
| Arthritis | <input type="checkbox"/> <input type="checkbox"/> | _____ | High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> <input type="checkbox"/> | _____ | Intestinal Polyps | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Bleeding Tendency | <input type="checkbox"/> <input type="checkbox"/> | _____ | Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> <input type="checkbox"/> | _____ | Leukemia | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Colitis | <input type="checkbox"/> <input type="checkbox"/> | _____ | Migraine | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Congenital Heart Disease | <input type="checkbox"/> <input type="checkbox"/> | _____ | Nervous Breakdown | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> <input type="checkbox"/> | _____ | Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Emphysema | <input type="checkbox"/> <input type="checkbox"/> | _____ | Sickle Cell Anemia | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Epilepsy | <input type="checkbox"/> <input type="checkbox"/> | _____ | Stomach Ulcers | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Goiter | <input type="checkbox"/> <input type="checkbox"/> | _____ | Stroke | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Gout | <input type="checkbox"/> <input type="checkbox"/> | _____ | Suicide | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Hay Fever | <input type="checkbox"/> <input type="checkbox"/> | _____ | Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Heart Attack | <input type="checkbox"/> <input type="checkbox"/> | _____ | Other | <input type="checkbox"/> <input type="checkbox"/> | _____ |

MEDICATIONS:

| | |
|---|---|
| <input type="checkbox"/> Asthma Wheezing Medicine | <input type="checkbox"/> Sleeping Pills/Tranquilizers |
| <input type="checkbox"/> Aspirin, Bufferin, Anacin, Tylenol or Similar Products | <input type="checkbox"/> Thyroid Medicine |
| <input type="checkbox"/> Blood Pressure Pills | <input type="checkbox"/> Stomach/Digestive Medicine |
| <input type="checkbox"/> Cortisone, Prednisone | <input type="checkbox"/> Weight-Reducing Pills |
| <input type="checkbox"/> Cough Medicine | <input type="checkbox"/> Blood Thinners or Coumadin |
| <input type="checkbox"/> Digitalis or Heart Medicine | <input type="checkbox"/> Dilantin or Seizure Medications |
| <input type="checkbox"/> Hormones | <input type="checkbox"/> Water Pills or Diuretics |
| <input type="checkbox"/> Insulin or Diabetic Pills | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Anemia Medications | <input type="checkbox"/> Phenobarbital/Barbiturates |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Vitamins |
| | <input type="checkbox"/> Other Prescription or Over the Counter Drugs |

Faña Medical Group
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Telephone Number: _____
SS#: _____ Birth Date: _____
Address: _____

I authorize (physician/group name) _____
to release the following information: _____

To: Faña Medical Group
Address: 6449 38th AVENUE NORTH SUITE F4
ST PETERSBURG, FL 33710
PHONE: 727-384-0192 FAX: 727-384-1500

For the Purposes of: _____
(You may indicate "At the request of the individual")

I authorize the release of the specified information from my medical record. Unless otherwise indicated, my authorization may include the release of the following, please strike through those you which to exclude, if any:

- My diagnosis and/or treatment for alcoholism and/or drugs abuse or dependency
- My diagnosis and/or treatment regarding mental health issues.
- HIV antibody test results and/or AIDS diagnosis and treatment.
- Genetic test results and/or related treatment.
- Other: _____

I understand that this authorization shall be in effect for one (1) year from the date signed. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office and if I do revoke this authorization it will not have any effect on the actions of Fana Medical Group took before the revocation was received.

A photocopy of this authorization constitute a valid authorization. I understand that once my records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies. I understand that my treatment or continued treatment by Fana Medical Group is in no way conditioned on whether or not I sign this authorization.

PROHIBITION ON REDISCLOSURE: The confidentiality of the information disclosed pursuant to this authorization is protected by the State and Federal Law. However, I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by the Federal privacy regulations.

Date: _____ Signed: _____
(Patient)

If patient is unable to consent because of physical/mental condition or age, complete the following:
Patient is: [] a minor _____ years of age. [] is unable to give authorization because _____

Date: _____ Signed: _____
Underline One: Parent/Guardian/POA/Conservator/Executor/Other

Personal Representative(s) must provide appropriate documentation to verify your legal authority to act on this patient's behalf.

Faña Medical Group

CONSENT FOR RELEASE of CONFIDENTIAL MEDICAL INFORMATION

I _____ hereby authorize Faña Medical Group to release my healthcare information to:

1. _____
Print name of party authorized to receive information Relationship to patient

Address of party listed above _____
Telephone number of party listed above
2. _____
Print name of party authorized to receive information Relationship to patient

Address of party listed above _____
Telephone number of party listed above
3. _____
Print name of party authorized to receive information Relationship to patient

Address of party listed above _____
Telephone number of party listed above

I authorize the release of my entire medical record via either telephonic, face-to-face, or written communication to the above named individual(s). Unless otherwise indicated, my authorization includes the release of the following, please strike those you wish to **exclude**, if any:

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
- My diagnosis and/or treatment regarding mental health issues.
- HIV antibody test results and/or AIDS diagnosis and treatment.
- Genetic test results and/or related treatment.
- Other: _____

[] By checking this box, I agree to allow messages containing personal health information on my answering machine. If this box is not checked, only brief, non-specific messages may be left.

I further release and indemnify Faña Medical Group, its affiliates, employees, officers and directors from any and all liability, which in any way results from the disclosure of the information pursuant to the above Instruction. This authorization shall remain in effect from the date signed until written revocation is received. I understand that I am under no obligation to sign this release of information and that it is my right to inspect all information disclosed, if I so request.

Signature of Patient

ID or SS#

Date of Birth

Date

Fana Medical Group Privacy Notice

This notice describes how protected health information may be used and disclosed and how you can access this information. Please review this notice.

Dear Patient:

Fana Medical Group is committed to treating and using Protected Health Information (PHI) about you responsibly. This Privacy Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information. This notice is effective October 1, 2005 and applies to all protected health information as defined by federal regulations. This notice refers to Fana Medical Group using terms “us”, “we”, or “our”.

Uses/Disclosures: We use PHI about you for treatment, payment and operational purposes. We do not require authorization to use your PHI for these purposes. There are several other reasons we may use your PHI without your acknowledgement. The information, also referred to as Medical Record or Health Record serves as:

- a) Communication among health care professionals who contribute to your care.
- b) Basis for planning your care and treatment.
- c) Method to assess quality compliance and outcomes.
- d) Source of Data for Medical Research.
- e) Legal document describe the care you received.
- f) Means by which you or a third party payer can verify that services were rendered.

Understanding what’s in your record and how your PHI is used helps you ensure its accuracy. In addition, it helps you better understand who, what, when, why and where others access your information.

What are your Medical Record Information Rights: The medical record is the physical property of Fana Medical Group, which contains information about you. You have the right to:

- a) Obtain a paper copy of this Privacy Notice upon request.
- b) Request a restriction on certain uses/disclosures of your PHI although we’re not required to agree.
- c) Inspect, amend and copy your medical records according to Federal Regulations.
- d) Receive PHI by alternative means or at alternative locations. (i.e. work)
- e) Revoke your authorization to use or disclose medical information except to the extent that action already has been taken.

Our Rights and Responsibilities: We at Fana Medical Group are required to:

- a) Charge a fee to copy your records.
- b) Maintain the privacy of your PHI.
- c) Reply within 60 days to inspect or copy PHI.
- d) Abide by the terms in this notice.
- e) Notify you in the event we were unable to agree to a requested restriction.
- f) Provide you with this Privacy Notice.
- g) Accommodate reasonable request you may have to communicate medical information by alternative means or at alternative locations.

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain as required by changes in Federal or State Regulations.

We will not use your medical information without your authorization, except as described here. We will also discontinue to use or disclose your PHI after receiving written revocation of the authorization according to the procedures in the authorization.

Fana Medical Group Privacy Notice

Examples of how we will use and or disclose your information:

1) How is my information used for payment?

You may receive a claim from an insurer that may contain information identifying you as well as the diagnosis for which you were treated.

2) Who else can view my information?

Our Business Associates such as Billing Services, transcription services. We also request from them to safeguard your PHI properly at the time we contract their services.

3) What about notifying my family or caregiver (s)?

We will disclose information using our best judgment to any person you identify (personal friend or family member) as long as it will be relevant to your health care or the payment thereof.

4) How is my information used for treatment?

Information obtained from clinical staff in our practice will be recorded in your record and used to determine proper treatment or diagnosis.

5) What other ways will my information be disclosed to other parties?

Marketing: We may contact you to remind you of office visits, test results or other health-related issues that may be beneficial to you.

Research: Upon approval of the proper Review Boards, we may occasionally disclose information to researchers.

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law allows your PHI to be released to a proper health oversight agency, public health agency or attorney provided that a work force member or associate believes in good faith we have not engaged in unlawful conduct or violated clinical or professional standards potentially endangering one or more patients, workers or the public.

You will be asked to sign an acknowledgement form upon receipt of this privacy notice. The purpose of this is to make you aware of how we may use and or disclose your PHI and for what purposes. We also want you to be aware of your privacy rights under these rules. If you decline to sign the acknowledgement form we will continue to provide you treatment as well as use and disclose your PHI for treatment, payment and healthcare operations when necessary. Your healthcare services will not be jeopardized or suspended in the event you refuse to sign the acknowledgement.

Questions? For additional information, please contact our privacy officer at 727-384-0192.

If you believe your rights have been violated, you can file a complaint with our officer or with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services. There will be no retribution for filing a complaint with either the Privacy Officer or the OCR. You may contact the OCR at:

Office for Civil Rights
US Dept of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Faña Medical Group
PRIVATE NOTICE ACKNOWLEDGMENT

Faña Medical Group is committed to providing you with all required information regarding your Privacy Rights as described by HIPAA (Health Insurance Portability and Accountability Act).

Attached to this acknowledgement you will find your personal copy of our Privacy Notice explaining how we use and disclose your health information. In the event that any significant changes to our policies are made a new Privacy Notice will be made available to you.

I, _____, acknowledge receipt of Faña Medical Group's Privacy Notice on this date.

Patient Signature

Date

If the patient refused the form:

____ Patient received Privacy Notice

____ Patient refused Privacy Notice

Witness

Date

**PATIENT CONTRACT FOR PAIN CONTROL
FANA MEDICAL GROUP, PA.**

The pain you are currently experiencing may be helped with the use of narcotic pain medication(s). A doctor may prescribe appropriate narcotic medication(s) for your specific type of pain. Narcotic pain medication(s) may:

- a. Become ineffective with time.
- b. Become habit forming or cause addiction.
- c. Cause severe constipation that requires frequent use of laxative.
- d. Interfere with your ability to operate complex machinery. It is recommended that you not drive an automobile or operate such machinery as power tools while taking narcotic medication(s).

I understand that I have a chronic pain problem that currently requires the prescription for narcotic pain medication(s) for relief of pain and to improve my functional ability. The risks, benefits and alternatives of medication have been discussed with me by the physician in detail, including but not limited to, drug dependency, respiratory depression, cardiovascular depression, liver and/or kidney damage, etc.

I will only receive my prescription(s) from my Primary Care Physician and have my prescription(s) filled at only one pharmacy. I will notify my treating physician of the name of the pharmacy.

I waive my right to privacy regarding these medication(s). My physician may contact any health care provider, legal authority or pharmacy to obtain or provide information about the patient's care.

I will take the medication(s) only as prescribed and will notify my physician if I do not. If necessary, I agree to random urine and blood test to assess my compliance.

I understand that the eventual goal is to taper off the narcotic medication(s). I agree to meet regularly with my physician to assess my progress.

Federal and state law regulates dispensing narcotic medication(s). Forging or altering a narcotic prescription(s) is a crime. Mandatory compliance by both the patient and physician is required. Failure to comply with all the laws regarding narcotic medication(s) may result in criminal action being taken against you.

Medication(s) will not be given early for any reason. **PRESCRIPTION(S) WILL ONLY BE GIVEN DURING REGULAR OFFICE HOURS AND WILL NOT BE GIVEN OR REFILLED BY THE PHYSICIAN DURING WEEKENDS.** No narcotics can be given over the telephone. If the prescription or the medication(s) are lost or stolen, a police report will be required for replacement. **NO AFTERHOURS CALLS WILL BE ACCEPTED FOR THESE MEDICATIONS.**

An increase in your pain will NOT necessarily be a reason to increase your pain medication(s). Contact the doctor if you feel a change in your medication(s) is needed.

Eliminating or rescuing the use of your narcotic medication(s) may be a treatment goal, and this may require hospitalization.

A psychological evaluation regarding addiction and drug dependency may be necessary for continuation of narcotics more than 3 (three) months.

Failure to follow these instructions may require the doctor to stop prescribing the narcotic medication(s) and recommend treatment in a psychiatric, substance abuse, or detoxification program. If this should occur, the doctor may still continue to manage your pain in other ways, such as with non-narcotic medication(s).

If I deviate from the above guidelines or if the medication(s) losses its effectiveness in increasing my function ability, I understand that the narcotic may be tapered off by the physician. My signature at the bottom indicates my understanding and agreement with the above guidelines. Failure to comply may result in dismissal from the practice. This agreement serving 30(thirty) days notice to find another physician.

Your signature below indicates that you have read and understand these instructions and that you agree to comply with the terms of this agreement.

PATIENT NAME (Print) _____ PATIENT SIGNATURE _____ DATE _____

PHYSICIAN NAME(Print) _____ PHYSICIAN SIGNATURE _____ DATE _____

WITNESS NAME (Print) _____ WITNESS SIGNATURE _____ DATE _____

PHARMACY NAME _____ PHARMACY TELEPHONE NUMBER _____

FANA Medical Group Healthcare Advance Directives

Your “Advance Directives” will allow you to express what your wishes are for your medical care if you ever become unable to make critical medical decisions yourself (Example: if you are in a coma).

To help answer some basic questions you may have on “Advance Directives” we have attached a question and answer sheet.

We have also enclosed the “Patient Self-Determination Questionnaire”. Please take a few minutes to complete this form. If you have any of these important medical directives already please bring an original copy with you on your initial visit. If you do not have these forms, you may want to contact your attorney who should have all of these forms and can assist you with completing these.

If you are unable to get these forms or have questions regarding “Advance Directives” check with a Fana Medical Group staff member for assistance when you come in for your initial visit.

Thank you for your time and for becoming a member of the Fana Medical Group family.

Advance Directives

What are advance directives?

“Advance Directive” is a general term that refers to your oral or written instructions about your future medical care in the event you become unable to speak for yourself.

What is a living will?

A living will is a type of advance directive in which you put in writing your wishes about medical treatment should you be unable to communicate your wishes.

What is a medical power of attorney?

A medical power of attorney is a document that lets you appoint someone you trust make decisions about your medical care if you cannot make those decisions yourself.

Why do I need an advance directive?

Advance directives give you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own decisions your advance directives will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment.

What happens if I don't have an advance directive?

In the event that you cannot speak for yourself, health and medical decisions may be made by someone not of your choosing or by the court.

Once I make an advance directive, can I cancel it?

Yes, your advance directive can be canceled or revoked by you at any time.

Who should I talk to about an advance directive?

Your Fana Medical Group Primary Care Physician is the best person to answer your questions. Your doctor has the knowledge and cares about you to put your concerns at ease. All the necessary paperwork and information is available at your Fana Medical Group Center. Ask your doctor or see the receptionist.

