PATIENT HANDBOOK

PHYSICIANS
SURGICAL HOSPITALS, L.L.C.

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SURGICAL HOSPITALS, L.L.C.

A Letter from the Executive Team

We would like to welcome you to Physicians Surgical Hospitals. Your healthcare needs are very important to us and we consider it a privilege and honor that you have selected Physicians Surgical Hospitals as your hospital of choice.

Our patient care teams, physicians and staff are honored to serve you and your family during your time of need. We are highly recognized at both the state and national level on quality and service. Together, we will do our very best to take care of you and your family.

The Physicians Surgical Hospitals family is driven to provide high-quality healthcare in a loving and caring environment. On behalf of our medical staff and dedicated employees, we welcome you to our Physicians Surgical Hospitals family.

Sincerely,
Physicians Surgical Hospitals

Pre-Admission Instructions

Step 1:
Please schedule a pre-admit appointment by calling the facility at which you will be receiving treatment:

☐ **Panhandle Surgical Campus**
7100 SW 9th Ave.
Amarillo, Texas 79106
806-212-0233

☐ **Quail Creek Surgical Campus**
6819 Plum Creek Drive
Amarillo, Texas 79124
806-354-6160

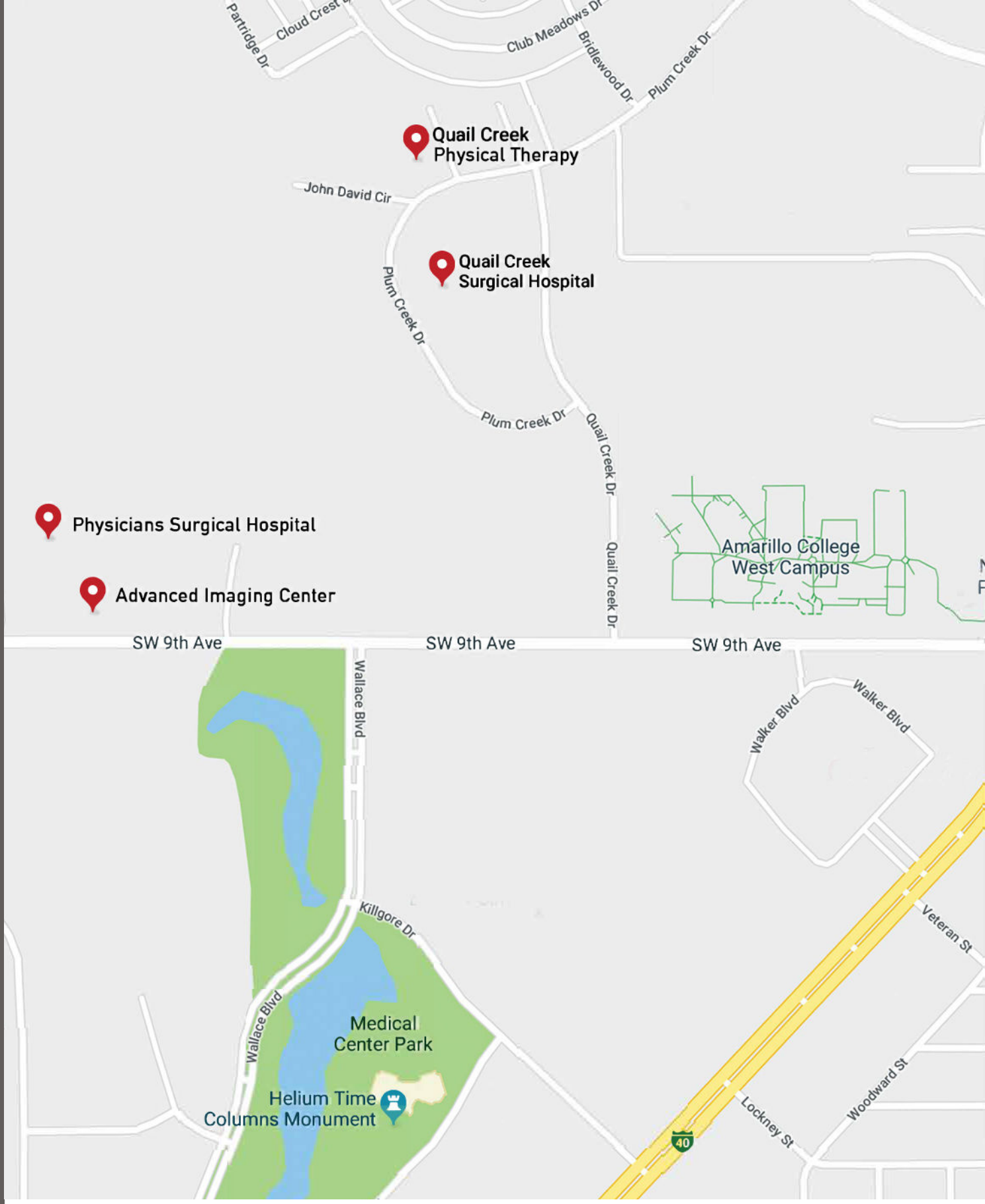
Step 2:
Two weeks prior to your pre-admit appointment, please pre-register by calling 806-351-3557.

Step 3:
Bring the following items to your pre-admit appointment:

- All current medications in their original bottles
- All paperwork from your doctor
- Co-Pay/Patient Responsibility Payment
- Driver License
- Insurance Card(s)

PATIENT HANDBOOK

OUR LOCATIONS



Advanced Imaging Center | 7010 SW 9th Ave. | Amarillo , TX 79106 | 806-351-8480

Panhandle Surgical Hospital | 7100 SW 9th Ave. | Amarillo, TX 79106 | 806-212-0247

Quail Creek Physical Therapy | 6900 John David Circle | Amarillo, TX 79124 | 806-212-8400

Quail Creek Surgical Hospital | 6819 Plum Creek Dr. | Amarillo, TX 79124 | 806-354-6100

WHAT TO BRING

To ensure a smooth admission process, please bring the following:

- Insurance identification card, Social Security card or Medicare card.
- All current medications you are taking in their original bottles.
- A list of all medications you are taking including herbal and over the counter (include strength and how often each medication is taken), as well as any food or medication allergies.
- Personal items such as toiletries and reading materials.
- Notepad and pen for questions you may want to ask during your doctors' visits.
- Some personal belongings require special care. Ask your nurse for a denture cup for your dentures and a personal belongings bag for any other items you may need to store. Be sure your name is on the cup or bag.

VALUABLES

We strongly recommend you leave valuables such as money, jewelry and credit cards with a family member or at home. If you arrive with an item you would like our staff to secure for you, please ask your nurse to have someone pick the item up from your room. You must be responsible for any item you choose to keep in your possession or leave in your room during your stay. Physicians Surgical Hospitals provide guests with wireless internet service if you choose to bring your electronic devices.

INTERPRETATION SERVICES

Interpretation services are available to you, free of charge, for many languages. IPads are available with sign language translations. If you need assistance with sign language, please notify your physician before you are scheduled to arrive for your appointment.

A TOBACCO-FREE CAMPUS

For the health of our patients, visitors and staff, Physicians Surgical Hospitals are tobacco-free campuses. Smoking, including the use of electronic cigarettes, is not allowed. Counselors from the BSA Harrington Cancer Center are available to help you quit. You may contact a counselor through your caregiver or you may leave a message at 806-463-QUIT (7848). We look forward to working with you and your family to make your tobacco-free stay with us as comfortable as possible.

KEEPING YOUR STAY PRIVATE

We understand some patients may prefer a little more privacy during their stay with us. If you do not want us to direct visitors or gifts to your room, you may elect to be a do not disclose patient. Please understand that if you elect to be a do not disclose patient, flowers and mail will not be delivered to your room and we will not be allowed to provide your room number to visitors. However, you may still provide visitors with your room number if you choose to do so. You will have the option to elect to be a do not disclose patient during the admitting process. If you change your mind after you have been admitted, you may request the do not disclose form from your nurse.

USING YOUR TELEPHONE

- **Local calls:** Dial "9-806" + the number you wish to reach.
- **To dial a patient room outside of the hospital:** Dial 806-212-1 + room number (Panhandle Surgical Hospital) Dial 806-354-1 + room number (Quail Creek Surgical Hospital).

PATIENT IDENTIFICATION

For your safety we may ask you for your name and date of birth multiple times throughout your stay. This is a common way for us to ensure proper identification.

FOOD SERVICE FOR PATIENTS

Patients will receive a menu from their food service ambassador to use when ordering meals. Ambassadors can then place patients' orders for them or show patients how to order meals themselves when they are ready.
Please be aware your meal selection or options may be determined by your treatment.

Meal service times:

- **Breakfast**: 6:30 a.m. to 10:00 a.m.
- **Lunch and Dinner:** 11:30 a.m. to 7:00 p.m.

VENDING MACHINES

Vending machines are located in the main lobby. For directions to the nearest vending machine, please ask a Physicians Surgical Hospital employee.

SPIRITUAL CARE

Chaplains are available 24 hours a day for spiritual and emotional support of patients and families. To speak with a chaplain or for the next chapel service time, call:

- 806-212-5343

VISITATION GUIDELINES

Visitors are chosen by the patient, including but not limited to, the patient's spouse, domestic partner (including same-sex domestic partners) and other family members and friends. With his/her consent, each patient has the right to receive visitors he/she designates regardless of whether the visitor is legally related to the patient or not and the patient has the right to withdraw or deny that consent.

Physicians Surgical Hospitals will not limit or deny visitation privileges based on race, color, national origin, religion, sex, gender identity, sexual orientation or disability. Physicians Surgical Hospitals may, when clinically necessary or reasonable, place limitations on the right to receive visitors. Physicians Surgical Hospitals may also limit visitation if given a court order to limit contact.

Visiting Panhandle Surgical Hospital

The main entrance can be accessed until 5 p.m. Once the main entrance is closed, visitors must use the Patient Stay Unit entrance.

Visiting Quail Creek Surgical Hospital

The main entrance can be accessed from 6 a.m. - 9 p.m. Once the main entrance is closed, visitors must use the call button to gain access to the main entrance.

GOING HOME

When it is time for you to leave the hospital, your doctor will write discharge orders that give approval for you to leave. If you have multiple doctors, each doctor treating you must give approval before you leave. This process may take several hours. Your nurse will give you instructions and prescriptions, if needed. Case managers are available on every nursing unit to assist you in making plans to go home.

MED+VAN SERVICE

Transport home is available through our MED+VAN service whether you are able to walk or require a wheelchair. A certified Emergency Care Attendant will take you from your room, drive you home and ensure you get safely inside. Contact our Dispatch Center by calling 806-655-6948 to check pricing or arrange transport

LOST AND FOUND

If a patient has lost an item, please check with front desk staff.

TOBACCO ADDICTION

Counselors from the BSA Harrington Cancer Center are available to help you stop using tobacco. You may contact a Tobacco Treatment Specialist at: 806-463-7848

SUICIDE PREVENTION

The Suicide Prevention Hotline number is:

- 806-359-6699 or
- 800-692-4039

9-8-8 offers 24/7 access to trained crisis counselors who can help people experiencing mental health-related distress.

PATIENT RIGHTS

Physicians Surgical Hospitals respect the rights of the patient and recognizes that each patient is an individual with unique healthcare needs. Because of the importance of respecting each patient, we strive to provide considerate, respectful care, focused on the patient's individual needs.

The Statement of Patient Rights shall include, but is not limited to your right as a patient to:

- Make informed decisions regarding your care and become informed in advance of, or when discontinuing the provision of care.
- Receive beneficiary notice of non-coverage and the right to appeal premature discharge.
- Considerate, dignified and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and exploitation.
- Access protective and advocacy services or have these services accessed on your behalf.
- Remain free from restraint and seclusion of any form that is not medically necessary or used as a means of coercion, discipline, convenience or retaliation by staff.
- Know the names of the hospital and staff that provide your care.
- Formulate advanced directives regarding your healthcare, and to have hospital staff and practitioners who provide your care to comply with these directives (to the extent provided by state laws and regulations).
- Have your personal physician notified promptly of your admission to the hospital and to have a family member or representative of your choice notified.
- Receive information from your physician about your illness, health status, diagnosis, course of treatment, outcomes of care and your prospects of recovery in terms that you or your patient representatives can understand.
- Examine and know what treatment costs and payment methods are available.
- Obtain information on disclosures of protected health information in accordance with federal, state and local laws.
- Decide whether to participate in educational projects, research or experiments relating to your care or treatment.
- Within the limits of the law, privacy and confidentiality of communication and records concerning your medical care.
- Expect that reasonable steps will be taken to ensure your personal safety and security at the hospital.
- You have the right to appropriate assessment and management of pain. Your doctor and nurse will assess your pain and involve you in decisions about managing pain effectively.
- If you are a hospitalized patient, you or your representative have the right to request a discharge planning evaluation at any time and to have that evaluation completed.

PATIENT RESPONSIBILITIES

You, as the patient, have the responsibility:

- To provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, pain and other health-related matters.
- To follow the treatment plan recommended by those responsible for your care.
- For your actions if you refuse treatment or do not follow the healthcare team's instructions.
- To see that your bills are paid as promptly as possible; following hospital rules and regulations.
- To be considerate of the rights of other patients and hospital personnel.
- To seek information, and in the event you have questions, to ask them.

ORGAN TISSUE DONATION

Organ Tissue Donation is an option available to patients and family members who wish, upon the patient's death, to make organs or tissue available to others. You may register to be a donor by:

1. Applying or renewing your driver's license.
2. Registering online at www.donatelifetexas.org.
3. Printing, completing and mailing a paper form from www.donatelifetexas.org.

Please ask your nurse, case manager or chaplain for more information and for forms to be completed if needed.

THE EARLY SYMPTOMS OF A HEART ATTACK

- Nausea
- Pain down both arms
- Fatigue
- Anxiety
- Chest pain, squeezing or discomfort
- Mild chest pressure, burning, aching or tightness
- Back pain
- Shortness of breath
- Feeling of fullness

ADDITIONAL SIGNS AND SYMPTOMS USUALLY IN WOMEN BUT CAN PRESENT IN MEN

- Pressure, fullness, squeezing pain in center of chest, spreading to the neck, shoulder or jaw
- Light-headedness, fainting, sweating, nausea, or shortness of breath with or without chest discomfort
- Upper abdominal pressure or discomfort
- Lower chest discomfort

HOW TO GIVE HANDS-ONLY CPR

If you see a teen or adult suddenly collapse, call 9-1-1 and push hard and fast in the center of the chest to the beat of the classic disco song "Stayin' Alive." CPR can more than double a person's chances of survival, and "Stayin' Alive" has the right beat for Hands-Only CPR.

SURVIVE
DON'T DRIVE

Call 9-1-1.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES effective date: December 2025

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected health information is stored electronically and is subject to electronic disclosure.
If you have any questions about this notice, please contact the Physicians Surgical Hospitals Privacy Officer at 806-212-5240.

This Notice Describes Our Practices And Those Of:

- Any medical staff member and any healthcare professional who participates in your care;
- Any volunteer we allow to help you while you are here; and
- All employees of any hospital, clinic, laboratory or other facility affiliated with BSA Health System. All of those people follow the terms of this notice. They may also share health information that identifies you (also known as "protected health information") with each other for treatment, payment or healthcare operations as described in this notice.

Our Pledge Regarding Health Information:

We understand that health information about you and your health is personal. We are committed to protecting health information about you. This notice will tell you about the ways that we may use and disclose health information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of protected health information. We are required to comply with any state laws that offer a patient/plan member additional privacy protections.

We Are Required By Law To:

- Maintain the privacy of health information that identifies you.
- Give you and other individuals this notice of our legal duties and privacy practices with respect to protected health information.
- Follow the terms of the notice that is currently in effect.
- Notify affected individuals in the event of a breach involving unsecured protected health information.

How We May Use And Disclose Your Health Information:

- **For Treatment.** We may use and disclose your health information to provide you with medical treatment or services and to coordinate your care. For example, a health care provider, such as a physician, nurse or other person providing health services will access your health information to understand your medical condition and history. To assist in your treatment and care coordination, we may share information with other providers and with accountable care organizations (known as "ACO's") in which you participate, including notifying them that you have received care from us.

- **For Payment.** We may use and disclose your health information for purposes of receiving payment for treatment and services that you receive. For example, we may disclose your information to health plans or other payors to determine whether you are enrolled with the payor or eligible for health benefits or to submit claims for payment. The information on our bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment. We may provide health information to entities that help us submit bills and collect amounts owed, such as a collection agency.

- **For Health Care Operations.** We may use and disclose your health information for operational purposes. For example, your health information may be used by, and disclosed to, members of the medical staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, to assess the quality of care and outcomes in your case and similar cases, to learn how to improve our facilities and services, for training, to arrange for legal or risk management services and to determine how to continually improve the quality and effectiveness of the healthcare we provide.

- **Facility Directory.** Unless you object, we may include you in the facility directory. This information may include your name, location in the facility, general condition (e.g., fair, stable, etc.) and religious affiliation. We may give your directory information, except for religious affiliation, to people who ask for you by name. Unless you object, your religious affiliation and other directory information may be released to members of the clergy even if they do not ask for you by name.

- **Others Involved In Your Care.** We may disclose relevant health information to a family member, friend, or anyone else you designate in order for that person to be involved in your care or payment related to your care. We may also disclose health information to those assisting in disaster relief efforts so that others can be notified about your condition, status and location.

- **Fund Raising.** We may use and disclose your health information to contact you about fundraising, consistent with legal requirements. You have the right to opt out of receiving these communications. Required By Law. We may use and disclose information about you as required by law. For example, we may disclose information to report gunshot wounds, suspected abuse or neglect or similar injuries and events.

- **Public Health**. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities (e.g., state health department, Center for Disease Control, etc.) to prevent or control disease, injury or disability, or for other public health activities. Texas law contains some reporting requirements, including population-based activities relating to improving health or reducing healthcare costs.

- **Law Enforcement Purposes.** Subject to certain restrictions, we may disclose information needed or requested by law enforcement officials.

- **Judicial And Administrative Proceedings**. We may disclose information in response to an
- appropriate subpoena, discovery request or court order.

- **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections to monitor the healthcare system.

- **Decedents.** Health information may be disclosed to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties.

- **Organ/Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

- **Research.** We may use or disclose your health information for research purposes after a receipt of authorization from you or when an institutional review board (IRB) or privacy board has waived the authorization requirement by its review of the research proposal and has established protocols to ensure the privacy of your health information. We may also review your health information to assist in the preparation of a research study.
- **Health And Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.
- **Government Functions.** Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.
- **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.
- **Business Associates**. We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information..
- **Other Uses And Disclosures.** We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. We may disclose your health information through Health Information Exchanges (HIEs) in which we participate for treatment, payment or other purposes described above as permitted by law. An HIE is a computer-based information system that helps providers securely share medical information, for purposes permitted by law such as coordinating care. Patients are generally included in the HIE unless they choose to opt out. To opt out of future disclosures through HIEs in which we participate, contact our Privacy Officer at the address at the end of this notice so that you can complete an HIE opt out form.
- **Additional Restrictions on Uses and Disclosures of SUD Treatment Information**
    - We may use your substance use disorder treatment records from programs subject to 42 CFR Part 2 ("SUD Program Information") without your consent to provide you with care within the SUD Program, and to share that information with others involved in your care within the SUD Program.
    - We also may disclose SUD Program Information without your consent as follows:
        - To medical personnel to the extent necessary to meet a bona fide medical emergency.
        - To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or SUD Program evaluation.
        - If a judge finds good cause to issue a court order, such as when the judge believes the order may avert a substantial risk of death or serious bodily harm.
        - To a public health authority, so long as the SUD Program Information provided is deidentified.
    - We will ask you to provide your written consent to use and disclose your SUD Program Information for purposes of other treatment, payment, and health care operations. Once you have provided your written consent, we may use and disclose your SUD Program Information as otherwise described in this Notice of Privacy Practices, except:
        - We are prohibited from using or disclosing your SUD Program Information, or testimony relaying the content of such records, in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent, or a court order after notice and an opportunity to be heard is provided to you.

YOUR HEALTH INFORMATION RIGHTS

You have the right to:

- Obtain a paper copy of this notice of information practices upon request, even if you have previously agreed to receive this notice electronically.
- Inspect and obtain a copy of your health information that we maintained.
- Request an amendment to your health information under certain circumstances.
- Request a confidential communication of your health information by alternative means or at alternative locations. Please be advised that this request for alternative means or locations of communications applies only to this provider or location.
- Receive an accounting of certain disclosures made of your health information.
- Request a restriction on certain uses and disclosures of your information. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or healthcare operations when you have paid for the item or service covered by the request out-of-pocket and in full and when the uses or disclosures are not required by law.

To exercise any of these rights, please contact our Privacy Officer at the address at the end of this notice.

This document shall provide notice to patients that the Texas Department of State Health Services, Texas Healthcare information Collection program (THCIC) receives patient claim data regarding services performed by the named Provider. The patients claim data is used to help improve the health of Texas, through various methods of research and analysis. Patient confidentiality is upheld to the highest standard and is not subject to public release. THCIC follows strict internal and external guidelines as outlined in Chapter 108 of the Texas Health and Safety Code and the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

For further information regarding the data being collected, please send all inquiries to:

Chris Aker
THCIC
Dept. of State Health Services
Center for Health Statistics, MC 1898
PO Box 149347
Austin, Texas 78714-9347

Location:
Moreton Building, M-660
1100 West 49th Street
Austin, Texas 78756

Phone: *512-776-7261 / Fax: 512-776-7740*

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice and make the new terms effective for all protected health information kept by Physicians Surgical Hospitals. We will post a copy of the current notice in our facility and on our website, www.physurg.com. You may also get a current copy by contacting our Privacy Officer at the address at the end of this notice.
The effective date of the notice is in the top right-hand corner of the page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Physicians Surgical Hospitals or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Physicians Surgical Hospitals, submit your written complaint to our Privacy Officer at the address at the end of this notice. You will not be penalized for filing a complaint.

CONTACT INFORMATION FOR QUESTIONS OR TO FILE A COMPLAINT

If you have any questions about this notice, want to exercise one of your rights that are described in this notice, or want to file a complaint, please contact the Physicians Surgical Hospitals Privacy Officer at:

Physicians Surgical Hospitals
Attn: *Privacy Officer*
Address: *1600 Wallace Blvd., Amarillo, TX 79106*
Phone: *806-212-5240*

PATIENT GRIEVANCES / COMPLAINTS

Physicians Surgical Hospitals recognize and honor your right as a patient and/or your family's right to file a complaint at any time there is a concern about the standard of care being provided or your safety. A patient grievance is a formal written or verbal complaint that is filed when a patient issue cannot be resolved promptly by staff present at the time of the complaint.

Filing a grievance / complaint will not adversely affect current or future patient care. The grievance / complaint will be investigated and findings will be reported back as quickly as possible.

THE GRIEVANCE PROCESS

1. If you wish to contact our accrediting agency, TJC, with a complaint, you may do so by:
   a. **Mail:** The Joint Commission / 1 Renaissance Boulevard / Oakbrook Terrace, Illinois 60181
   b. **Telephone:** 1-800-994-6610

2. A complaint may be filed directly with the Texas Department of State Health Services by:
   a. **Mail:** Health Facility Licensing and Compliance Division
      Texas Department of State Health Services
      110 W. 49th Street / Austin, Texas 78756
   b. **Fax:** 512-834-6653
   c. **Telephone notification to the Compliance Hotline:** 888-973-0022

3. A complaint may also be filed directly to PSH by calling the Grievance Hotline at 806-212-3456

PATIENT HANDBOOK

In accordance with the provisions of Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act and the Regulations of the U.S. Department of Health and Human Services issued pursuant to those statutes, Physicians Surgical Hospitals, LLC (PSH) complies with the applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender or sexual orientation. PSH does not exclude people or treat them differently because of race, color, national origin, age, disability, gender or sexual orientation.

Physicians Surgical Hospitals

- Provides free aids and services to people with disabilities to communicate effectively with us.
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- Provides convenient off-street parking designated specifically for disabled persons.
- Provides Curb cuts and ramps between parking areas and buildings
- Fully accessible office, meeting rooms, bathrooms, public waiting areas, patient treatment areas, including examining rooms and patient wards.

If you need any services or aids listed above, please let the receptionist or your nurse know.

If you believe that PSH has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, gender or sexual orientation, you can file a grievance with:

PSH Section 504/1557 Coordinator/Compliance Officer
1600 Wallace Blvd, Amarillo, Texas 79106
Phone 806-212-5240
State Relay Number: 711 or Texas state Relay Service
at (800)735-2988 [voice] or (800)735-2989 [TTY]

If you need help filing a grievance, PSH Section 504/1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by:

MAIL: U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH
Building Washington, D.C. 20201

PHONE: 1-800-368-1019, 800-537-7697 (TDD)

LANGUAGE ASSISTANCE SERVICES

SPANISH	ATENCIÓN: Si necesita servicios de asistencia lingüística, están disponibles para usted de forma gratuita.
BURMESE	သတိပြုပါ။ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို အခမဲ့ ပေးနိုင်ပါသည်။
SWAHILI	ANGALIZO: Ikiwa unahitaji huduma za usaidizi wa lugha, zinapatikana bila malipo.
KAREN	သတိပြုပါ။ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို အခမဲ့ မည်သည့်အခါမဆို ရရှိနိုင်ပါသည်။
KIRUNDI	ICITANGAZO: Nimba ukeneye ubufasha mu rurimi, izo serivisi ziraboneka ku buntu.
CROATIAN	PAŽNJA: Ako trebate usluge jezične pomoći, dostupne su vam besplatno.
AMHARIC (Ethiopia)	ማስታወሻ፡ የቋንቋ እርዳታ አገልግሎቶች ከነፃ ይሰጡዎታል።
PERSIAN (Farsi)	توجه: اگر به خدمات کمک زبانی نیاز دارید، این خدمات به‌صورت رایگان در دسترس شما هستند.
LAOTIAN	ໂຕ໊ອນ: ຖ້າທ່ານຕ້ອງການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ບໍລິການນີ້ມີໃຫ້ທ່ານຟຣີ.
SOMALI	OGEYSIIS: Haddii aad u baahan tahay adeegyo caawinta luqadda, waa lagu heli karaa lacag la’aan.
VIETNAMESE	CHÚ Ý: Nếu bạn cần dịch vụ hỗ trợ ngôn ngữ, các dịch vụ này có thể được cung cấp miễn phí.
CHINESE	注意：如果您需要语言协助服务，我们将免费为您提供
KOREAN	주의: 언어 지원 서비스가 필요하시면 무료로 제공합니다.
ARABIC	تنبيه: إذا كنت بحاجة إلى خدمات المساعدة اللغوية، فهي متاحة لك مجانًا.
URDU	توجہ: اگر آپ کو زبان کی مدد کی خدمات کی ضرورت ہو، تو یہ آپ کو مفت فراہم کی جاتی ہیں۔
TAGALOG	PAALALA: Kung kailangan mo ng tulong sa wika, available ang mga serbisyo nang libre.
FRENCH	ATTENTION: Si vous avez besoin de services d’assistance linguistique, ils sont disponibles gratuitement.
HINDI	ध्यान दें: यदि आपको भाषा सहायता सेवाओं की आवश्यकता है, तो ये सेवाएँ निःशुल्क उपलब्ध हैं।
GERMAN	ACHTUNG: Wenn Sie Sprachhilfe benötigen, stehen Ihnen diese Dienste kostenlos zur Verfügung.
GUJARATI	સાવધાની: જો તમને ભાષા સહાય સેવાઓની જરૂર હોય, તો તે તમને મફતમાં મળી શકશે.
RUSSIAN	ВНИМАНИЕ: Если вам нужны языковые услуги, они предоставляются вам бесплатно.
JAPANESE	注意：言語支援サービスが必要な場合、無料でご利用いただけます。

DIFFICULT DECISIONS

In every hospital, there are times when a person's life can be sustained only through the use of mechanical or artificial means or procedures, thus prolonging the imminent moment of death.

The Directive to Physicians, Family and Surrogates (commonly known as a Living Will) aids you in communicating with your physician about your desired medical treatments in the event you have an irreversible or terminal illness. If you would like a Directive to Physicians, Family and Surrogates form, please ask your nurse and he or she will be happy to provide one.

INSTRUCTIONS FOR COMPLETING AN ADVANCE DIRECTIVE

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 healthcare provider, or medical institution may provide you with various resources to assist you in completing your Advance Directive. Brief definitions are listed on the next page 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 TO PHYSICIANS AND FAMILY OR SURROGATES

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

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 and 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 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 of all 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 if I 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 of a 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 of a 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 without life-sustaining treatment provided in accordance with 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 lifesustaining 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 perfonnance 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.

In-Hospital Do-Not-Resuscitate Order

Advance Directives Act (see §166.203, Texas Health and Safety Code)

After being admitted to the hospital, you or your legal guardian or agent under a medical power of attorney have the following rights:

1. The right to prepare written and dated directions to issue a Do-Not-Resuscitate Order
2. The right to give oral directions to issue a Do-Not-Resuscitate Order
    a. Your oral directions must be delivered to or observed by two competent adult witnesses.
    b. One of the witnesses cannot be an employee of your attending physician or an employee of the health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of a health care facility or of any parent organization of the health care facility
3. The right to complete an advanced directive (living will)
4. The right to revoke a Do-Not-Resuscitate Order or advanced directive (living will)
    a. You may revoke an in-hospital Do-Not-Resuscitate Order, an out-of-hospital Do- Not-Resuscitate Order, or an advanced directive (living will) at any time.
    b. You may revoke a Do-Not-Resuscitate Order or advanced directive (living will) by:
        i. Canceling, defacing, obliterating, burning, tearing, or otherwise destroying the directive or DNR order;
        ii. Signing and dating a written revocation that expresses intent to revoke the directive or DNR order; or
        iii. Expressing orally to any person providing direct care to you a revocation of the directive or an intent to revoke a DNR order.

Medical Power of Attorney Designation of Health Care Agent

Advance Directives Act (see §166.164, Texas Health and Safety Code)

I, _____ (insert your name) appoint:

Name: .....

Address: .....

Phone .....

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS: .....

.....

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: .....

Address: .....

Phone .....

B. Second Alternate Agent

Name: .....

Address: .....

Phone .....

The original of this document is kept at:

.....

.....

.....

The following individuals or institutions have signed copies:

Name: .....

Address: .....

.....

Name: .....

Address: .....

.....

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED.

I revoke any prior medical power of attorney.

DISCLOSURE STATEMENT.

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT. YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because ''health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment. psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you lo be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person bas to choose between acting as your agent or as your health or residential care provider: the law docs not allow a person to serve as both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

(I) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR

(2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;

(2) a person related to you by blood or marriage:

(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law:

(4) your attending physician;

(5) an employee of your attending physician;

(6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or

(7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand !the information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBUC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____ day of

_____ (month, year) at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

State of Texas
County of_____

This instrument was acknowledged before me on_____ (date) by

_____(name of person acknowledging).

_____
NOTARY PUBLIC, State of Texas

Notary's printed name:

_____

My commision expires:

_____

OR

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this medical power of attorney on _____ day of

_____ (month, year) at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

STATEMENT OF FIRST WITNESS:

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature:_____

Print Name:_____Date:_____

Address:_____

SIGNATURE OF SECOND WITNESS

Signature:_____

Print Name:_____Date:_____

Address:_____

NOTES

PHYSICIANS
SURGICAL HOSPITALS, L.L.C.

A BSA AND PHYSICIAN-OWNED AWARD-WINNING HOSPITAL