Horton Community Hospital

240 West 18th

Horton, Kansas 66439

785-486-2642

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

NAME ______________________________ SSN _________________________

MRN# __________________ DATE OF BIRTH __________________________

PLEASE READ THE FOLLOWING FOUR STATEMENTS

1. **I have been given written materials about my right to accept or refuse medical treatments.**
2. **I have been informed of my rights to formulate Advance Directives.**
3. **I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.**
4. **I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law.**

PLEASE CHECK ON OF THE FOLLOWING STATEMENTS:

________ I HAVE executed an Advance Directive

________ I HAVE NOT executed an Advance Directive

SIGNED _______________________________ DATE _____________________

WITNESS ______________________________ DATE _____________________