BAY COMMUNITY

Bay Community Health
Patient Information Sheet

Bay Community Health welcomes you and your family, and we appreciate the opportunity to provide your health care services! Please read the following information, which is provided to help meet your needs and answer questions about our practice.

Providers

Medical Providers

Wayne D. Bierbaum, M.D.*	Internal Medicine
Jonathan J. Hennessee, D.O.	Family Medicine
Thomas Sheesley, D.O. *	Family Medicine
William P. Jones, MD	Family Medicine
Harvey J. Steinfeld, MD	Family Medicine
Nancy Bryant, C.R.N.P.	Nurse Practitioner, Family Medicine
Ann Hendon, P.A. – C.	Physician Assistant

*Anne Arundel Medical Center (AAMC) Hospital Privileges

Behavioral Health Providers

Jana Raup, PhD, L.C.P.C	Behavioral Health
Joy Goodie, LCPC	Behavioral Health
Barbara Ripani, LCSW-C	Behavioral Health

Office Hours	West River		Shady Side	
	Medical	Behavioral Health	Medical	Behavioral Health
Monday	7:00 am – 5:30 pm	9:00 am – 6:00 pm	8:00 am – 5:00 pm	Closed
Tuesday	7:00 am – 5:30 pm	8:00 am – 8:00 pm	7:00 am – 5:00 pm	Closed
Wednesday	7:00 am – 8:00 pm	8:00 am – 8:00 pm	7:00 am – 5:00 pm	Closed
Thursday	7:00 am – 8:00 pm	9:00 am – 8:00 pm	8:00 am – 5:00 pm	3:30 pm – 6:30 pm
Friday	7:00 am – 4:30 pm	9:00 am – 5:00 pm	8:00 am – 4:00 pm	Closed
Saturday	Closed	8:00 am – 1:00 pm	Closed	Closed

Appointment Scheduling

- Established patients should arrive 15 minutes prior to appointment time / New patients should arrive 30 minutes prior
- Sick visits are typically scheduled for the same day or within 48 hours of appointment request
- Same-day and walk-in appointments are granted based on availability
- Follow-up office visits are scheduled at check-out
- Physical exams/well exams are usually scheduled within 2 to 6 weeks of appointment request
- Our providers may occasionally be running late, and your visit may be delayed. Our staff will try to inform you if this occurs.
- 48-hour advance notice on all cancellations is requested

Return Telephone Messages

Our providers and/or medical support staff attempt to return all messages in a timely fashion. Return calls are often made during the lunch or late afternoon hours and sometimes on the following day.

Prescriptions

Our providers believe that patients should be evaluated prior to being prescribed new medications. Prescription refills should be made through the pharmacy, which requires patients to inform their pharmacy with 48 hours advanced notice. "Controlled substance" medications will not be prescribed on Fridays or on the day before a

Federal holiday and in most cases will require an appointment with the primary provider. Some written prescriptions need to be picked up at the office and cannot be called in to a pharmacy. To avoid delays with medication refills, please review medication needs at each office visit.

Medical Referrals

You may require a medical referral for specialty and/or urgent care. Bay Community Health requests 5 working days to process these referrals. In many cases an office evaluation will be requested to determine the referral's necessity. Urgent care and/or emergency department visits may also require prior authorization. Please contact the office within 48 hours of an urgent care or emergency department visit to determine whether it has been authorized. Please remember that there are many health insurance companies many more individual policies. It is the patient's responsibility to know and abide by the regulations of his or her insurance coverage.

Medical Records/Medical Forms

In order to obtain a copy of Bay Community Health medical records patients must complete a "Request for Medical Records" form and allow a minimum of 5 working days for processing. The processing fee varies depending on the size of the medical chart, but the basic fee is typically $25.00. There is no charge to obtain copies of immunization records or records pertaining to State of Maryland Workman's Compensation. Depending on the form, there may be a charge applied to the patient bill for this processing. It may also be necessary for the patient to be evaluated in the office prior to form completion.

Authorization for Release of Medical Records

Bay Community Health
134 Owensville Road
West River, Md. 20778
(T) 410-867-4700 (F) 855-772-1468

I authorize the following protected health information to be released from the medical record of:

Last Name	First Name	Today's Date
Birthdate	Email Address	Phone Number

Release Records
- ☐ **To**
- ☐ **From**

Bay Community Health
134 Owensville Road
West River, Md. 20778
(T) 410-867-4700
(F) 410-867-4934

Release Records
- ☐ **To**
- ☐ **From**

Name/Organization

Address

City / State / Zip

Phone Fax

☐ **Please mail my records** ☐ **Please call when my records are ready for pick up** ☐ **Please fax my records**
☐ **Other:** _____

I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Maryland privacy law, the information may no longer be protected by Federal and Maryland privacy laws once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

TO BE RELEASED	**Date of Service / Provider**	**TO BE RELEASED**	**Date of Service / Provider**
☐ Chart Summary		☐ Immunizations	
☐ Office visit & lab		☐ Physical Therapy notes	
☐ GYN visit & lab		☐ Radiology reports	
☐ Urgent Care visits		☐ Entire Record	
☐ Lab work		☐ Other	

➔ Note: If specific dates to be released or a specific provider are not indicated, all records in the category marked will be released.

Indicate the PURPOSE for this disclosure:_____
I understand the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand I have the right to revoke this authorization I must do so in writing and in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____.
If I fail to specify and expiration date, event or condition, this authorization will expire in six months of dated signature. I understand that authorizing the disclosure of this phi is voluntary. I need not sign this for in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact BCH Privacy Officer.
I understand that I may incur a charge for the copying or inspection of patient records. A minimum clerical fee of $_____and per page fee of $_____.

Signature of Patient or Patient Representative	Printed Name/Relationship of Patient Representative	Date

If documents are being picked up at BCH, from someone other than the patient. This authorization form must indicate this accordingly

Signature of person picking up documents	Printed Name/Relationship	Date

BAY COMMUNITY HEALTH

Bay Community Health
134 Owensville Road
West River MD 20778
Phone: 410 867-4700 / Fax: 410 867-4934

Patient Name _____ **DOB:** _____

Patient preferred telephone number to be contacted: _____

Please indicate additional persons with whom we may contact on your behalf and indicate their relationship to you:

Name	Relation to Patient	Telephone #	Phone Type
			H W C
			H W C
			H W C
			H W C
			H W C

Patient additional comments: _____

Signature: _____ **Date:**_____

Print Name: _____

BCH Employee Initials: _____

BAY COMMUNITY HEALTH

Date:_____

Legal Name *Last*	*First*	*Middle Initial*	*Maiden Name (if Married)*
Legal Sex: ☐ Male ☐ Female	**Date of Birth** Month / Day / Year		**Social Security #**

Please be aware that the name & sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. Your answers to the following question will help us reach you quickly & discretely with important information

Home Phone ( )	**Cell Phone** ( )	**Work Phone** ( )	**Best number to use:** ( ) Home ( ) Cell ( ) Work
Please indicate if OPC may leave a message for you on the following numbers: ( ) Home ( ) Cell			
Local Address	City	State	Zip
Billing Address (if different from above)	City	State	Zip
Email Address		☐ Do not have email address ☐ Prefer not to share email address	
Responsible Party Name	**Phone Number**	**Relationship to you**	
Responsible Party Address	City	State	Zip
Emergency Contact's Name	**Phone Number**	**Relationship to you**	

This information is for Bureau of Primary Health Care reporting purposes and ensures federal funding to serve our patients. We respect that this is personal and confidential information. Your cooperation in completing this section is appreciated.

1) **Which category best describes your current annual income?** ☐ < $15,000 ☐ $15,001-$25,000 ☐ $25,001-$35,000 ☐ $35,001-$50,000 ☐ >$50,001 2) **Family Size:** _____ Total # of family members residing in the same house	3) **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered	4) **Employment status:** ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired 5) **Student status:** ☐ Student Full Time ☐ Student Part Time ☐ Not a Student	6) **Racial Group(s)** ☐ Asian ☐ Black/African American ☐ American Indian/ Alaska Native ☐ Native Hawaiian/ Other Pacific Islander ☐ White/Caucasian 7) **Ethnicity** ☐ Hispanic/Latino/Latina ☐ Not Hispanic/Latino/Latina
8) **Language(s)** ☐ English ☐ Spanish ☐ Other: _____ 9) **Require translation services** ☐ Yes ☐ No 10) **Veteran Status** ☐ Veteran ☐ Not a Veteran	11) **Seasonal Worker?** ☐ Yes ☐ No 12) **Migrant Worker?** ☐ Yes ☐ No 13) **Homeless since January this year?** ☐ Yes ☐ No 14) **Public housing Resident?** ☐ Yes ☐ No	15) **How did you learn about OPC:** ☐ Friend/Family ☐ Other Doctor's Office ☐ Insurance Company ☐ Postcard/Mailing ☐ Hospital/ER ☐ Internet Advertising ☐ Capital ☐ Bay Weekly ☐ Chesapeake Family ☐ Other: _____	16) **Do you think of yourself as:** ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Something else ☐ Don't Know ☐ Choose not to disclose
What gender do you identify with? ☐ Male ☐ Female ☐ Choose not to disclose ☐ Trans Male ☐ Trans Female ☐ Other: _____			***Please Turn Over***

BAY COMMUNITY HEALTH

Date:_____

Please indicate below if you have a preferred pharmacy for filling prescriptions:

Preferred Pharmacy:		**City**	

Payment/Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD AT THE TIME OF REGISTRATION. A list of insurance we accept is available on our website. Our registration staff can also assist you.

METHOD OF PAYMENT

I understand and acknowledge that payment is due at the time service is rendered. This includes all co-payments and co-insurance responsibilities. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen. We accept Cash, Checks, Money Orders, Visa, MasterCard, American Express, and Discover.

INSURANCE AUTHORIZATION, ASSIGNMENT AND PAYMENT OF SERVICES

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Bay Community Health for any services furnished me by that party who accepts assignment/clinical provider. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to be released in order to process payment of such services. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. I also understand that it is my responsibility to be knowledgeable of my insurance benefits and requirements. I understand that based on my health insurance policy, there may be services that the Clinical Provider of OPC may deem necessary that may not be covered by my health insurance, and I shall be held responsible for the payment of such services. I understand and acknowledge that payment is due at the time service is rendered. This includes co-payments, patient responsibility percentage of office visit/procedural charge and any previous back charges. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen.

AUTHORIZATION TO TREAT

Permission is hereby given to the Clinical Providers of Bay Community Health (BCH), to administer such diagnostic, operative, or treatment procedures to the above named patient that are deemed necessary. This includes accessing information from an online pharmacy database about medications that I may be taking for the purpose of continued treatment.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's *Notice of Privacy Policies*, detailing how my information may be used and disclosed as permitted under federal and state law.

ADVANCE DIRECTIVE

I acknowledge receipt of "Advance Directives" pamphlet/form. This information was given to me *as* part of my "New Patient" documents. I fully intend to read this pamphlet, and should I decide to choose the use of the advance directives, I will complete the form and will return the signed document back to OPC to maintain with my medical records.

The below signature acknowledges your agreement to the above disclosures:

X _____ **Date:** _____

_____ _____

MARYLAND ADVANCE DIRECTIVE:
PLANNING FOR FUTURE HEALTH CARE DECISIONS

A Guide to

Maryland Law on

Health Care Decisions

(Forms Included)

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

Brian E. Frosh
Attorney General

February 2014

Dear Fellow Marylander:

I am pleased to send you an advance directive form that you can use to plan for future health care decisions. The form is *optional;* you can use it if you want or use others, which are just as valid legally. If you have any legal questions about your personal situation, you should consult your own lawyer. If you decide to make an advance directive, be sure to talk about it with those close to you. The conversation is just as important as the document. Give copies to family members or friends and your doctor. Also make sure that, if you go into a hospital, you bring a copy. Please *do not* return completed forms to this office.

Life-threatening illness is a difficult subject to deal with. If you plan now, however, your choices can be respected and you can relieve at least some of the burden from your loved ones in the future. You may also use another enclosed form to make an organ donation or plan for arrangements after death.

Here is some related, important information:

- If you want information about Do Not Resuscitate (DNR) Orders, please visit the website http://marylandmolst.org or contact the Maryland Institute for Emergency Medical Services Systems directly at (410) 706-4367. A Medical Orders for Life-Sustaining Treatment (MOLST) form contains medical orders regarding cardiopulmonary resuscitation (CPR) and other medical orders regarding life-sustaining treatments. A physician or nurse practitioner may use a MOLST form to instruct emergency medical personnel (911 responders) to provide comfort care instead of resuscitation. The MOLST form can be found on the Internet at: http://marylandmolst.org. From that page, click on "MOLST Form."

- The Maryland Department of Health and Mental Hygiene makes available an advance directive focused on preferences about mental health treatment. This can be found on the Internet at: http://www.dhmh.state.md.us/mha. From that page, click on "Forms."

I hope that this information is helpful to you. **I regret that overwhelming demand limits us to supplying one set of forms to each requester.** But please feel free to make as many copies as you wish. Additional information about advance directives can be found on the Internet at: http://www.oag.state.md.us/healthpol/advancedirectives.htm.

Brian E. Frosh
Attorney General

HEALTH CARE PLANNING
USING ADVANCE DIRECTIVES
Optional Form Included

Your Right To Decide

Adults can decide for themselves whether they want medical treatment. This right to decide - to say yes or no to proposed treatment - applies to treatments that extend life, like a breathing machine or a feeding tube. Tragically, accident or illness can take away a person's ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will. These decisions should reflect your own values and priorities.

A Maryland law called the Health Care Decisions Act says that you can do health care planning through "advance directives." An advance directive can be used to name a health care agent. This is someone you trust to make health care decisions for you. An advance directive can also be used to say what your preferences are about treatments that might be used to sustain your life.

The State offers a form to do this planning, included with this pamphlet. The form as a whole is called "Maryland Advance Directive: Planning for Future Health Care Decisions." It has three parts to it: Part I, Selection of Health Care Agent; Part II, Treatment Preferences ("Living Will"); and Part III, Signature and Witnesses. This pamphlet will explain each part.

The advance directive is meant to reflect your preferences. You may complete all of it, or only part, and you may change the wording. You are *not* required by law to use these forms. Different forms, written the way you want, may also be used. For example, one widely praised form, called *Five Wishes,* is available (for a small fee) from the nonprofit organization Aging With Dignity. You can get information about that document from the Internet at www.agingwithdignity.org or write to: Aging with Dignity, P.O. Box 1661, Tallahassee, FL 32302.

This optional form can be filled out without going to a lawyer. But if there is anything you do not understand about the law or your rights, you might want to talk with a lawyer. You can also ask your doctor to explain the medical issues, including the potential benefits or risks to you of various options. You should tell your doctor that you made an advance directive and give your doctor a copy, along with others who could be involved in making these decisions for you in the future.

In Part III of the form, you need two witnesses to your signature. Nearly any adult can be a witness. If you name a health care agent, though, that person may not be a witness. Also, one of the witnesses must be a person who would not financially benefit by your death or handle your estate. You do not need to have the form notarized.

This pamphlet also contains a separate form called "After My Death." Like the advance directive, using it is optional. This form has four parts to it: Part I, Organ Donation; Part II, Donation of Body; Part III, Disposition of Body and Funeral Arrangements; and Part IV, Signature and Witnesses.

Once you make an advance directive, it remains in effect unless you revoke it. It does not expire, and neither your family nor anyone except you can change it. You should review what you've done once in a while. Things might change in your life, or your attitudes might change. You are free to amend or revoke an advance directive at any time, as long as you still have decision-making capacity. Tell your doctor and anyone else who has a copy of your advance directive if you amend it or revoke it.

If you already have a prior Maryland advance directive, living will, or a durable power of attorney for health care, that document is *still valid.* Also, if you made

an advance directive in another state, it is valid in Maryland. You might want to review these documents to see if you prefer to make a new advance directive instead.

Part I of the Advance Directive: Selection of Health Care Agent

You can name anyone you want (except, in general, someone who works for a health care facility where you are receiving care) to be your health care agent. **To name a health care agent, use Part I of the advance directive form.** (Some people refer to this kind of advance directive as a "durable power of attorney for health care.") Your agent will speak for you and make decisions based on what you would want done or your best interests. You decide how much power your agent will have to make health care decisions. You can also decide when you want your agent to have this power — right away, or only after a doctor says that you are not able to decide for yourself.

You can pick a family member as a health care agent, but you don't have to. Remember, your agent will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care agent. Also, consider picking one or two back-up agents, in case your first choice isn't available when needed. Be sure to inform your chosen person and make sure that he or she understands what's most important to you. When the time comes for decisions, your health care agent should follow your written directions.

We have a helpful booklet that you can give to your health care agent. It is called *"Making Medical Decisions for Someone Else: A Maryland Handbook."* You or your agent can get a copy on the Internet by visiting the Attorney General's home page at: http://www.oag.state.md.us, then clicking on "Guidance for Health Care Proxies." You can request a copy by calling 410-576-7000.

The form included with this pamphlet does *not* give anyone power to handle your money. We do not have a standard form to send. Talk to your lawyer about planning for financial issues in case of incapacity.

Part II of the Advance Directive: Treatment Preferences ("Living Will")

You have the right to use an advance directive to say what you want about future life-sustaining treatment issues. You can do this in Part II of the form. If you both name a health care agent and make decisions about treatment in an advance directive, it's important that you say (in Part II, paragraph G) whether you want your agent to be strictly bound by whatever treatment decisions you make.

Part II is a living will. It lets you decide about life-sustaining procedures in three situations: when death from a terminal condition is imminent despite the application of life-sustaining procedures; a condition of permanent unconsciousness called a persistent vegetative state; and end-stage condition, which is an advanced, progressive, and incurable condition resulting in complete physical dependency. One example of end-stage condition could be advanced Alzheimer's disease.

FREQUENTLY ASKED QUESTIONS ABOUT ADVANCE DIRECTIVES IN MARYLAND

1. Must I use any particular form?

No. An optional form is provided, but you may change it or use a different form altogether. Of course, no health care provider may deny you care simply because you decided not to fill out a form.

2. Who can be picked as a health care agent?

Anyone who is 18 or older except, in general, an owner, operator, or employee of a health care facility where a patient is receiving care.

3. Who can witness an advance directive?

Two witnesses are needed. Generally, any competent adult can be a witness, including your doctor or other health care provider (but be aware that some facilities have a policy against their employees serving as witnesses). If you name a health care agent, that person cannot be a witness for your advance directive. Also, **one** of the two witnesses must be someone who (i) will not receive money or property from your estate and (ii) is not the one you have named to handle your estate after your death.

4. Do the forms have to be notarized?

No, but if you travel frequently to another state, check with a knowledgeable lawyer to see if that state requires notarization.

5. Do any of these documents deal with financial matters?

No. If you want to plan for how financial matters can be handled if you lose capacity, talk with your lawyer.

6. When using these forms to make a decision, how do I show the choices that I have made?

Write your **initials** next to the statement that says what you want. **Don't** use checkmarks or X's. If you want, you can also draw lines all the way through other statements that do not say what you want.

7. Should I fill out both Parts I and II of the advance directive form?

It depends on what you want to do. If all you want to do is name a health care agent, just fill out Parts I and III, and talk to the person about how they should decide issues for you. If all you want to do is give treatment instructions, fill out Parts II and III. If you want to do both, fill out all three parts.

8. Are these forms valid in another state?

It depends on the law of the other state. Most state laws recognize advance directives made somewhere else.

9. How can I get advance directive forms for another state?

Contact Caring Connections (NHPCO) at 1-800-658-8898 or on the Internet at: http://www.caringinfo.org.

10. To whom should I give copies of my advance directive?

Give copies to your doctor, your health care agent and backup agent(s), hospital or nursing home if you will be staying there, and family members or friends who should know of your wishes. Consider carrying a card in your wallet saying you have an advance directive and who to contact.

11. Does the federal law on medical records privacy (HIPAA) require special language about my health care agent?

Special language is not required, but it is prudent. Language about HIPAA has been incorporated into the form.

12. Can my health care agent or my family decide treatment issues differently from what I wrote?

It depends on how much flexibility you want to give. Some people want to give family members or others flexibility in applying the living will. Other people want it followed very strictly. Say what you want in Part II, Paragraph G.

13. *Is an advance directive the same as a "Patient's Plan of Care", "Instructions on Current Life-Sustaining Treatment Options" form, or Medical Orders for Life-Sustaining Treatment (MOLST) form?*

No. These are forms used in health care facilities to document discussions about current life-sustaining treatment issues. These forms are not meant for use as anyone's advance directive. Instead, they are medical records, to be done only when a doctor or other health care professional presents and discusses the issues. A MOLST form contains medical orders regarding life-sustaining treatments relating to a patient's medical condition.

14. *Can my doctor override my living will?*

Usually, no. However, a doctor is not required to provide a "medically ineffective" treatment even if a living will asks for it.

15. *If I have an advance directive, do I also need a MOLST form?*

Yes. The MOLST form contains medical orders that will help ensure that all health care providers are aware of your wishes. If you **don't** want emergency medical services personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have a MOLST form containing a DNR order signed by your doctor or nurse practitioner or a valid EMS/DNR form.

16. *Does the DNR Order have to be in a particular form?*

Yes. Emergency medical services personnel have very little time to evaluate the situation and act appropriately. So, it is not practical to ask them to interpret documents that may vary in form and content. Instead, the standardized MOLST form has been developed. Have your doctor or health care facility visit the MOLST web site at http://marylandmolst.org or contact the Maryland Institute for Emergency Medical Services System at (410) 706-4367 to obtain information on the MOLST form.

17. *Can I fill out a form to become an organ donor?*

Yes, Use Part I of the "After My Death" form.

18. *What about donating my body for medical education or research?*

Part II of the "After My Death" form is a general statement of these wishes. The State Anatomy Board has a specific donation program, with a pre-registration form available. Call the Anatomy Board at 1-800-879-2728 for that form and additional information.

19. *If I appoint a health care agent and the health care agent and any back-up agent dies or otherwise becomes unavailable, a surrogate decision maker may need to be consulted to make the same treatment decisions that my health care agent would have made. Is the surrogate decision maker required to follow my instructions given in the advance directive?*

Yes, the surrogate decision maker is required to make treatment decisions based on your known wishes. An advance directive that contains clear and unambiguous instructions regarding treatment options is the best evidence of your known wishes and therefore must be honored by the surrogate decision maker.

Part II, paragraph G enables you to choose one of two options with regard to the degree of flexibility you wish to grant the person who will ultimately make treatment decisions for you, whether that person is a health care agent or a surrogate decision maker. Under the first option you would instruct the decision maker that your stated preferences are meant to guide the decision maker but may be departed from if the decision maker believes that doing so would be in your best interests. The second option requires the decision maker to follow your stated preferences strictly, even if the decision maker thinks some alternative would be better.

REVISED JANUARY 2013

IF YOU HAVE OTHER QUESTIONS, PLEASE TALK TO YOUR DOCTOR OR YOUR LAWYER. OR, IF YOU HAVE A QUESTION ABOUT THE FORMS THAT IS NOT ANSWERED IN THIS PAMPHLET, YOU CAN CALL THE HEALTH POLICY DIVISION OF THE ATTORNEY GENERAL'S OFFICE AT (410) 767-6918 OR E-MAIL US AT ADFORMS@OAG.STATE.MD.US.

MORE INFORMATION ABOUT ADVANCE DIRECTIVES CAN BE OBTAINED FROM OUR WEBSITE AT:

http://www.oag.state.md.us/Healthpol/AdvanceDirectives.htm

MARYLAND ADVANCE DIRECTIVE:
PLANNING FOR FUTURE HEALTH CARE DECISIONS

By: _____ **Date of Birth:** _____
(Print Name) (Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. **Make sure you talk to your health care agent (and any back-up agents) about this important role.** Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

➔ You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive. »

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

B. Selection of Back-up Agents
(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

_____

Telephone Numbers: _____
(home and cell)

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Decide who my doctor and other health care providers should be; and

3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

4. I also want my agent to:

   a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and

   b. Be able to visit me if I am in a hospital or any other health care facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

This power is subject to the following conditions or limitations:
(Optional; form valid if left blank)

_____

_____

_____

_____

_____

_____

D. How my Agent is to Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult
(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make decisions.

Name(s)	**Telephone Number(s):**
_____	_____
_____	_____
_____	_____
_____	_____

F. In Case of Pregnancy
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

_____

_____

G. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of this Part
(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

✎_____

>>OR<<

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability **permanently.**

✎_____

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, go to Part II. Also consider becoming an organ donor, using the separate form for that.

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. Statement of Goals and Values

(Optional: Form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

_____

_____

_____

_____

B. Preference in Case of Terminal Condition

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎_____

C. Preference in Case of Persistent Vegetative State
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎_____

D. Preference in Case of End-Stage Condition
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎_____

E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

F. In Case of Pregnancy
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____

_____

_____

_____

G. Effect of Stated Preferences
(Read both of these statements carefully. Then, initial **one** only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

   ✎_____

   >>OR <<

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

   ✎_____

PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

_____ _____

(Signature of Declarant) (Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s):

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s):

(**Note:** Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law does **not** require this document to be notarized.)

AFTER MY DEATH

(This document is optional. Do only what reflects your wishes.)

By: _____ **Date of Birth:** _____
(Print Name) (Month/Day/Year)

PART I: ORGAN DONATION

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate: ✎_____
Any needed organs, tissues, or eyes. ✎_____
Only the following organs, tissues or eyes:

_____

_____

_____

I authorize the use of my organs, tissues, or eyes:

For transplantation ✎_____

For therapy ✎_____

For research ✎_____

For medical education ✎_____

For any purpose authorized by law ✎_____

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. *This document is not intended to change anything about my health care while I am still alive.* After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

PART II: DONATION OF BODY

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

✎_____

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my advance directive. ✎_____

>>OR<<

This person:

Name: _____

Address: _____

_____

Telephone Number(s): _____
(Home and Cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

_____

_____

_____

PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

_____ _____
(Signature of Donor) (Date)

The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

_____ _____
(Signature of Witness) (Date)

_____
Telephone Number(s):

_____ _____
(Signature of Witness) (Date)

_____
Telephone Number(s):

AFTER MY DEATH

Part II: Donation of Body

The State Anatomy Board, a unit of the Department of Health and Mental Hygiene administers a statewide Body Donation Program. Anatomical Donation allows individuals to dedicate the use of their bodies upon death to advance medical education, clinical and allied-health training and research study to Maryland's medical study institutions. The Anatomy Board requires individuals to pre-register prior to death as an anatomical donor to the state Body Donation Program. There are no medical restrictions or qualifications to becoming an a "Body Donor". At death the Board will assume the custody and control of the body for study use. It is truly a legacy left behind for others to have healthier lives. For donation information and forms you can contact the Board toll-free at 800.879.2728

Did You Remember To ...

- ☐ Fill out Part I if you want to name a health care agent?
- ☐ Name one or two back-up agents in case your first choice as health care agent is not available when needed?
- ☐ Talk to your agents and back-up agent about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions in the advance directive?
- ☐ If you want to make specific decisions, fill out Part II, choosing carefully among alternatives?
- ☐ Sign and date the advance directive in Part III, in front of two witnesses who also need to sign?
- ☐ Look over the "After My Death" form to see if you want to fill out any part of it?
- ☐ Make sure your health care agent (if you named one), your family, and your doctor know about your advance care planning?
- ☐ Give a copy of your advance directive to your health care agent, family members, doctor, and hospital or nursing home if you are a patient there?

BAY COMMUNITY HEALTH

BAY COMMUNITY HEALTH
Medical History Form

Name _____ **Date of Birth** _____

Address _____ **Home Phone #** _____

_____ **Work Phone #** _____

Social Security # _____ **Occupation** _____ **Cell Phone #** _____

HOSPITALIZATION/SURGERY

Date	Reason

IMMUNIZATIONS

Hepatitis B	YES	NO	When _____
Pneumovax	YES	NO	When _____
Flu	YES	NO	When _____
Tetanus	YES	NO	When _____

DRUG ALLERGIES

_____

_____

_____

MEDICATION LIST

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

MEDICAL HISTORY

____ Ringing in Ear
____ Ear Infections-Frequent
____ Dizziness/Fainting
____ Failing Vision
____ Eye Infections
____ Nose Bleeds
____ Sinus Trouble
____ Sore Throats-Frequent
____ Hayfever/Allergies
____ Pneumonia
____ Bronchitis/Chronic Cough
____ Asthma/Wheezing
____ Chest Pain
____ High Blood Pressure
____ Heart Murmur
____ Swollen Ankles
____ Leg Pain- walking
____ Varicose Veins/Phlebitis
____ Loss of Appetite
____ Difficulty Swallowing
____ Indigestion or Heartburn
____ Persistent Nausea/Vomiting
____ Peptic Ulcers
____ Abdominal Pain-Chronic
____ Gall Bladder Trouble
____ Jaundice/Hepatitis
____ Change in Bowel Habits
____ Diarrhea
____ Constipation
____ Diverticulosis
____ Crohn's/Colitits

____ Bloody or Tarry Stools
____ Hemorrhoids
____ Hernia
____ Urine Infections-Frequent
____ Blood in Urine
____ Kidney Stones
____ Venereal Disease
____ Urethral Discharge
____ Chronic Fatigue
____ Weight Loss-Recent
____ Anemia
____ Bruise Easily
____ Cancer
____ Diabetes
____ Thyroid Disease
____ Convulsions/Seizures
____ Stroke
____ Tremor/Hands Shaking
____ Muscle Weakness
____ Numbness/Tingling Sensations
____ Headaches-Frequent
____ Arthritis/Rheumatism
____ Osteoporosis
____ Back Pain-Recurrent
____ Bone Fracture/Joint Injury
____ Gout
____ Foot Pain
____ Cold Numb Feet
____ Rashes/Hives
____ Psoriasis
____ Eczema

____ Nervousness
____ Depression
____ Memory Loss
____ Moodiness-Excessive
____ Phobias
____ Mental Illness
____ Lactose Intolerance
____ Prostate Disease
____ Sexual Menstruation Dysfunction
____ Frequent Infections
____ Diphtheria
____ Tetanus
____ Chicken Pox
____ Polio
____ Mumps
____ Measles
____ Rubella
____ Rheumatic Fever
____ Scarlet Fever
____ Tuberculosis
____ Herpes

URINATION

____ Overnight > than twice
____ Painful
____ Loss of Control
____ Decrease in Force/Flow

____ Other _____
____ Other _____
____ Other _____
____ Other _____

BAY COMMUNITY HEALTH

BAY COMMUNITY HEALTH
Medical History Form

PLEASE TURN FORM OVER

FEMALES (Please Complete)

Pregnant	YES	NO	Menstrual Flow:	____	Regular	Days of Flow	_____
Planning Pregnancy	YES	NO		____	Irregular	Length of Cycle	_____
Pain/Bleeding during or after sex	YES	NO		____	Pain/Cramps		

Number of:

____ Pregnancies
____ Miscarriages
____ Abortions
____ Live Births

Birth Control Method _____
Name of Birth Control Pill _____

Do you have your Well Woman Exam (PAP and Breast Exam) done at Bay Community Health? ***Yes*** ***No***

Are you:	Test	Provider/Organization Name	Date Last Done
21 yrs or older (females only)	**Pap Smear**		/ /
40 yrs or older (females only)	**Mammogram**		/ /
50 yrs or older (female & male)	**Colonoscopy**		/ /

FAMILY HISTORY

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

	Which Family Members	Approx. when Diagnosed
Alcoholism		
Asthma		
Bleeding Disorder		
Cancer		
Diabetes		
Glaucoma		
Epilepsy/Convulsions		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Mental Illness		
Migraine		
Osteoporosis		
Stroke		
Thyroid Disease		
Other _____		
Other _____		

HABITS

____ Alcohol Type _____ Amount _____ How Long _____
____ Smoke Daily Qty _____ How Long _____
____ Coffee Cups Daily _____

PREVENTION

Do you wear seatbelts?	YES	NO	If no, why not?	_____
Do you wear a bike helmet?	YES	NO	N/A	
Do you have a working smoke detector?	YES	NO	N/A	
If there is a gun in your home, is it out of children's reach and unloaded?	YES	NO		
Do you wish to be tested for AIDS?	YES	NO		
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	YES	NO	If yes, explain	_____

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	☐ Male ☐ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

1

CPR (RESUSCITATION) STATUS: EMS providers must follow the *Maryland Medical Protocols for EMS Providers.*

_____ **Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

_____ **Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation.

_____ **Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

_____ **No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

Patient's Last Name, First, Middle Initial	Date of Birth	Page 2 of 2 ☐ Male ☐ Female

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

2 ARTIFICIAL VENTILATION

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit_____

2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.
Time limit_____

2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

3 BLOOD TRANSFUSION

3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.

3b. _____ Do not give any blood products.

4 HOSPITAL TRANSFER

4a. _____ Transfer to hospital for any situation requiring hospital-level care.

4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

5 MEDICAL WORKUP

5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition.

5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.

5c. _____ Do not perform any medical tests for diagnosis or treatment.

6 ANTIBIOTICS

6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.

6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.

6d. _____ Do not treat with antibiotics.

7 ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION

7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.
Time limit_____

7d. _____ Do not provide artificially administered fluids or nutrition.

8 DIALYSIS

8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. _____ May give dialysis for a limited period.
Time limit_____

8c. _____ Do not provide acute or chronic dialysis.

9 OTHER ORDERS _____

_____

_____

_____

_____

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

INSTRUCTIONS

Completing the Form: The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician, NP, or PA signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to a competent patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

Selecting CPR (Resuscitation) Status: EMS Option A-1 – Intubate, Option A-2 – Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set of interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

No-CPR Option A: Comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest / DNR if Arrest – No CPR. This choice may be made either with or without intubation as a treatment option. Prior to arrest, all interventions allowed under *The Maryland Medical Protocols for EMS Providers*. Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devices used for ventilatory assistance. In all cases, comfort measures will also be provided. No CPR if arrest occurs.

No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest. DNR if Arrest Occurs – No CPR. Prior to arrest, interventions may include opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medications by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by this original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable *Maryland Medical Protocols for EMS Providers*. Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility, and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

Location of Form: The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a copy, and a faxed MOLST form are all valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

Reviewing the Form: These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians, NPs, or PAs shall review and update, if appropriate, the MOLST orders **annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.**

Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form.

Voiding the Form: To void this medical order form, the physician, NP, or PA shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

Revoking the Form's DNR Order: In an emergency situation involving EMS providers, the DNR order in Section 1 may be revoked at any time by a competent patient's request for resuscitation made directly to responding EMS providers.

Bracelets and Necklaces: If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing. If a metal bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic Alert requires a copy of this order along with an application to process the request.

How to Obtain This Form: Call 410-706-4367 or go to marylandmolst.org

Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician, NP, or PA sign, cut off strip, fold, and insert in bracelet or necklace.

☐ DNR A-1 Intubate ☐ DNR A-2 Do Not Intubate ☐ DNR B

Pt. Name _____ DOB _____

Practitioner Name _____ Date _____

Practitioner Signature _____ Phone _____

BAY COMMUNITY HEALTH
Notice of Privacy Practices
Effective Date: January 1, 2013

This notice describes how health information about you may be used and disclosed and how you can get this information. PLEASE READ IT CAREFULLY.

Our Pledge to You about Protecting Your Health Information We at Bay Community Health (BCH) understand that health information about you and your health care is personal. We are committed to protecting this most private information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal doctor or health care practitioner or others working in this office. This notice will tell you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and certain obligations we have to use or disclose it. LAW REQUIRES US TO:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy with respect to your health information; and
- Follow the terms of this notice currently in effect

How We May Use and Disclose Health Information About You ***For Treatment*** We may use health information about you to provide you with health care treatment or services. We may disclose information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our office, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or other reasons. The information is needed by these professionals in order to know what treatments you will need. They will record actions taken in the course of your treatment and note how you respond. In the event of a disaster, we may also disclose health information about you to another organization assisting in disaster relief so that your family can be notified about your condition, status and location. ***Communications with Family*** Using our best judgment, we may disclose to a family member, personal representative, or any other person you identify, health information about you related to that person's involvement in you care if you do not object, or in the event of an emergency. ***Appointments*** We may use your information to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you. ***For Payment*** We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The bill may contain information that identified you, your diagnosis, and treatment or supplies you received in the course of care. ***For Health Care Operations*** We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Health Information Exchanges We may participate in various health information exchanges to facilitate the secure exchange of your electronic health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

Health Care Oversight Activities We may disclose health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, inspections, and licensure. They are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. ***As Required by Law*** We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings;
- To assist law enforcement officials in their duties, and
- To report information related to victims of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

To Avert a Serious Threat to Health and Safety We may use or disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. Any disclosure, however, would only be made to someone able to help prevent the threat. ***For Public Health*** We may use or disclose your health information for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report reactions to medications or problems with products;
- To notify people of recalls for products they may be using, and
- To notify a person who may have been exposed to disease or may be at risk for contracting the disease or condition.

Military or Veterans If you are a member of the armed forces or separated/discharged from military service, we may release health information about you as required by military command authorities or the Department of Veteran Affairs. We may also release health information about foreign military personnel to the appropriate foreign military authorities. ***Workers Compensation*** We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness. ***Coroners, Health Examiners and Funeral Directors*** We may release health information to a coroner or health examiner. For example, this may be necessary to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties. ***Inmates*** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release may be necessary for the institution to provide you with the health care, to protect your health and safety or that of

others, or for the safety and security of the correctional institution. ***Government Functions*** We may release health information to specialized government functions such as protection of public officials (President of the United States and others), or reporting to various branches of the armed services, authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. ***Lawsuits and Disputes*** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Your Health Information Rights The health and billing records we maintain are the physical property of Bay Community Health. The information in them, however, belongs to you. You have a right to: ***Inspect and Copy*** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy notes. To inspect and/or copy health information you must request this in writing using the form that we will provide to you upon request. Medical Record copies may be processed by an independent company, and a fee by this company or by Bay Community Health is billed to the patient. The fee varies based on the individual's medical records and specifics of the request, and the request will be processed within 2 to 3 weeks of date of the request. We may deny your request to inspect and copy your health information in very limited circumstances. If you are denied access to your health information, you may request a review of the denial. The person conducting the review will
not be the same one that denied your request. We will comply with the outcome of this review. ***Right to Amend*** If you feel that health information we have about you is incorrect or incomplete; you may ask us to amend the information. To request an amendment you need to submit your request in writing, on one page of paper, legibly handwritten or typed to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. In addition, you must provide the reason for wanting to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we share information as previously described. ***Right to an Accounting of Disclosures*** You have the right to request a list of accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, or health care operations, as previously described. To request a list of disclosures, you must submit your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. Your request must state a time frame that may be no longer than six (6) years and may not include dates prior to April 13, 2003. The first list you request within a twelve-month period will be free. For additional lists, we will charge you the cost of providing the list. We will notify you of the cost involved and you may choose to modify or withdraw your request at that time and before the costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and the date by which we can supply the list, but this date will not exceed a total of 60 days from the date you made the request. ***Right to Request Restrictions.*** You have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or friend. ***We are not required to agree to your request for restrictions if we are not able to ensure our compliance or if we believe it will negatively impact the care we may provide you.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. In your request, you must tell us what information you want to limit and to whom you want the limits to apply. ***Right to Request Confidential Communications*** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example; you can ask that we only contact you at work or by mail to a post office box. To request confidential communications, you must make your request in writing to Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. ***Right to a Paper Copy of this Notice.*** You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778.

Changes to this Notice We reserve the right to change this notice. We reserve the right to make revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Bay Community Health, HIPAA Officer, 134 Owensville Road, West River, MD 20778. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

Acknowledgement of Receipt of this Notice
We will request that you sign a separate form or notice acknowledging that you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date the acknowledgement form. This acknowledgement will be filed with your records.

Bay Community Health sincerely respects your privacy rights, and will make every reasonable attempt to protect your health information. It is important that you read this notice carefully, and if you have questions or concerns regarding this notice, please contact:

Bay Community Health
Attention: HIPAA Officer
134 Owensville Road
West River MD 20778
410-867-4700

BAY COMMUNITY
HEALTH

Bay Community Health

Notice of Privacy Practices Acknowledgement

Effective Date: January 1, 2013

I have been provided a paper copy of the Notice of Privacy Practices effective as of the date above.

_____
Patient's Name

_____
Patient's Signature

_____
Date

TO BE RECORDED IN PMS/SCANNED IN EPR