Dr. Ronald Bush

ACKNOWLEDGEMENT OF RECEIPT AND PRIVACY PRACTICES

I have received a copy of the “Notice Of Privacy Practices”. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (760) 200-2992 or by requesting the Notice in person at: The Medical Center At Indian Wells, 45280 Club Dr, Indian Wells Ca, 92210

Signature _____ Date _____

Name _____

As the representative of the above individual, I acknowledgement receipt of the Notice on his/her behalf.

Signature _____ Date _____

Name _____ Relationship to Patient _____

Acknowledgement

Name _____ Date of Birth _____

Telephone _____

Address _____

City _____ State / Province _____

Postal / Zip Code _____

This acknowledges that the physician, or his staff members, have provided me with information concerning Advance Directives.

1. I am age 18 or older.

◯ Yes ◯ No

2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning the Advance Directives. I under stand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.

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

   a. A durable power of Attorney For Health Care.

   b. The declaration in the A Natural Death Act-Ex. A Living Will

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

Signature

Date