***ACKNOWLEDGEMENT OF RECEIPT OF ADVANCED DIRECTIVE MATERIALS***

Notice to Patient:

Southeast Physician Network, P.C. (SPN), has as required by the Patient Self-Determination Act, provided to me information concerning advance health care directives in the form of an information booklet. I understand that this booklet is provided for informational purposes only and describes in general terms the law and my rights with regards to advance healthcare directives. I understand this information is intended to serve only as a source of information and that information is subject to change as the law changes.

I acknowledge that I have received a copy from this office regarding advance health care directives and agree that I have not received instructions from this office regarding the completion of this form, but instead been advised to seek legal counsel or other advisor on completion of this form.

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*Please print your name here*

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*Signature*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of advance health care directive information from this patient but it could not be obtained because:

* The patient refused to sign.
* Due to an emergency situation, it was not possible to obtain an acknowledgement.
* We were not able to communicate with the patient.
* Other *(Please provide specific details)*

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*Employee signature Date*