Patient Rights

Missouri

FREEMAN
Health System

Welcome to Freeman Health System

As a patient, you have many options for your healthcare needs, and we sincerely thank you for choosing Freeman Health System. We are dedicated to respecting your dignity and honoring your preferences regarding medical care while upholding the highest standards of treatment.

Our team is committed to providing exceptional care to every patient. If there's anything we can do to assist you during your stay, please don't hesitate to reach out. In Joplin, call *417.347.4940*, in Neosho, call *417.347.4300*, and in Ft Scott, call *620.768.0390*.

Kind regards,

Matthew W. Fry
President and Chief Executive Officer

Our mission is to improve the health of the communities we serve through contemporary, innovative, quality healthcare solutions.

FREEMAN WEST
Full-Service General Acute Care
1102 W. 32nd St.
Joplin, MO 64804
417.347.1111

FREEMAN EAST
Outpatient and Post-Acute Care Behavioral Health Services
932 E. 34th St.
Joplin, MO 64804
417.347.1111

FREEMAN NEOSHO
General Acute Care
113 W. Hickory St.
Neosho, MO 64850
417.451.1234

FREEMAN FORT SCOTT
General Acute Care
401 Woodland Hills Blvd
Fort Scott, KS 66701
620.768.0391

OZARK CENTER
Behavioral Health Services
1105 E. 32nd St.
Joplin, MO 64804
417.347.7600

FREEMAN®
Health System

freemanhealth.com

Patient Rights and Responsibilities

Accessing Care and Services

As a patient, you have the following rights:

- To receive notification of your patient rights in writing and information concerning important hospital policies and a list of available supportive resources, such as an ethics committee, patient advocate and pastoral and spiritual services, in advance of furnishing or discontinuing patient care whenever possible.
- To request treatment and receive considerate and respectful care from hospital personnel.
- To receive clear and effective communication that considers impairments of hearing, speech, vision, and language barriers.
- To expect medically appropriate health services from the hospital within its capabilities. Although treatment referral or transfer may be medically appropriate, you will be informed of the risks, benefits, and alternatives prior to the transfer of your care to other health care providers. You will not be transferred from the hospital until another institution accepts to receive you for care.
- To voice concerns you may have regarding the care you receive and have those concerns reviewed and resolved. We make every effort to deliver the highest quality of compassionate care and meet expectations for service. If you have complaints, we suggest you first discuss them with your nurse, the manager of the area, and/or your doctor. If your complaint remains unresolved, please request to speak with a Patient Liaison or contact Patient Relations at *417.347.4940*.
- To access an internal (Hospital) or external grievance process for the timely review of concerns or more serious issues that may affect care, and to receive a written notice of any decision made regarding your concern. The telephone number and address of the Freeman Patient Relations Department and available state agency is listed below.
- To expect your physician and family members or representatives will be notified promptly of your admission to the hospital, unless you request this not be done.
- To access available communications, including mail and telephones, and permitted visitors unless either communication method clinically contraindicates your care or safety. Any restrictions, however, will be explained to you.

In Receiving Treatment

As a patient, you have the following rights:

- To be involved in the development and implementation of your plan of care and to receive information from your physician to enable your informed decision and consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, at a minimum, the specific procedures and/or treatment proposed, the medically significant risks involved, the benefits of the procedure, and the medical alternatives, if any, available.
- To receive medically necessary and appropriate care.
- To obtain understandable information concerning your diagnosis and health status, proposed treatment and prognosis, and the financial implications associated with the available treatment choices.
- To know the name of the physician responsible for coordinating your care, as well as the identities of other health care members involved in your care.
- To refuse treatment, to the extent permitted by law, including being informed of the medical consequences of refusal of treatment.
- To the appropriate assessment and management of your pain.
- To be free from restraints or seclusion that are not medically necessary or are imposed as a means of coercion, discipline, convenience, or retaliation by staff, or used in a manner that is not consistent with federal or state regulations.

- Safe use of restraints or seclusion by trained staff when needed.
- To consent or decline to take part in research and/or experimental procedures affecting your care.
- To have your rights protected during research, investigation, and clinical trials involving human subjects.
- To be informed by the practitioner responsible for your care of any continuing health care needs following discharge from the hospital.
- To know if the hospital has relationships with outside individuals that may influence your treatment and care. These relationships may be with educational institutions, other health care providers or insurers.

Personal Privacy and Confidentiality

As a patient, you have the following rights:

- To confidentiality and personal privacy concerning your medical care program. Case discussion, consultation, examination, and treatment are confidential. Those not directly involved in your care must have your permission to be present during any medical or nursing treatments or discussion of your care.
- To receive care in a safe setting, free from abuse or harassment.
- To expect all communications and records pertaining to your care are treated as confidential. Permission in writing is necessary before the hospital will release any health care information, except as may otherwise be required by law.
- To reasonable access and review of your medical records.
- To receive visitors you designate including but not limited to a spouse, domestic partner, another family member or a friend regardless of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. You also have the right to withdraw or deny visitation privileges based on your preferences.

For security purposes, certain areas of this facility may be under video surveillance and may be temporarily recorded. Security camera placement has been made with sensitivity to a patient's right to personal privacy.

Advance Healthcare Directives and End of Life Decisions

As a patient, you have the following rights:

- To inform the hospital of any advance directives for healthcare, such as a living will or power of attorney for healthcare, that express your care and treatment wishes should you be unable to express those wishes. If you have a written advance directive, you should provide copies to your physician, the hospital, and your family. If you do not have one and wish to receive information concerning advance directives, we can provide you with information.
- To have end-of-life issues related to your care addressed with dignity and sensitivity, and to participate in any discussion concerning any ethical issues arising from your care.
- If you have any ethical issues or concerns regarding your care or if you need assistance with community resources, you are encouraged to contact a hospital Patient Liaison at *417.347.6677*, the Pastoral Care Department at *417.347.6627*, or the nurse manager on duty.
- Once an agreed-upon plan of care is determined, to follow the established treatment plan as the coordinated plan of care and the interventions for pain relief.
- To be responsible for your own decisions if you refuse treatment or do not follow the practitioner's instructions concerning the treatment plan.

Billing

As a patient, you have the following rights:

- To examine and receive an explanation of your hospital bill.
- To access the cost, itemized, when possible, of services rendered within a reasonable period of time.
- To be informed of the source of the hospital's reimbursement for his/her services, and of any limitations which may be placed upon his/her care.

Concerns or Questions

It is the policy of Freeman Health System that our patients are informed of their rights and given the opportunity to present their concerns. Should you have concerns you may voice your concern to your care provider or nurse or request a Patient Liaison to assist in enhancing your health care experience.

If you have any questions regarding these rights, concerns about safety issues, concerns about a possible rights violation, or a grievance you wish to file in regard to your care, please ask to speak with a nurse manager of the unit where you are a patient or contact Patient Relations at *417.347.4940*. Grievances will be addressed by a Patient Relations member within seven (7) business days of receipt from the patient or nurse manager. Grievances may also be mailed to: Freeman Patient Relations, 1102 W 32nd St. Joplin, MO 64804.

You may also lodge grievances directly by contacting the Missouri Department of Health and Senior Services, Bureau of Hospital Standards at PO Box 570, 920 Wildwood Dr., Jefferson City, MO 65102-0570; (Phone) *1.800.392.0210*; (Email) *hospitalcomplaints@health.mo.gov*.

Commence Health is a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) that helps Medicare beneficiaries with issues related to quality of care, coverage decisions, or premature discharges for Medicare beneficiaries wishing to seek review by the Quality Improvement Organization (QIO). You may file a complaint or grievance by contacting the following agency; Commence Health, the BFCC-QIO for Missouri, at PO Box 2687, Virginia Beach, VA 23450 (Phone) *1.888.755.5580* (TTY: 711); (Email); *LivantaQIO.cms.gov.*

Patient Responsibilities

As a patient, you have the responsibility:

TO PROVIDE INFORMATION

- Provide accurate and complete information concerning your current health status, complaints, past medical history and all other matters that may affect medical treatment.
- Communicate to your physician or health care provider whether or not you understand the course of your medical treatment and what is expected of you.
- Inform your health care provider that you do not wish to be photographed for educational purposes or medical documentation, unless required by law.

TO PARTICIPATE IN TREATMENT

- Follow the treatment plan established by your physician, including instructions from nurses and other health care professionals as they carry out the physician's orders.
- Take responsibility for your actions and the consequences, should you refuse treatment, not follow physician's orders or leave the hospital against the advice of your physician.
- Inform your health care provider if you wish to change your advance medical directive.
- Patients should ensure the fulfillment of financial obligations related to hospital care within a reasonable period of time and take personal responsibility for arrangement, payment, and liability of any private duty care.

CODE OF CONDUCT

In order to effectively provide medical treatment to you, Freeman Health System requires a commitment by staff, patients, and visitors alike. Mutual trust and respect can help us provide the right treatment plan, in a safe and respectful environment that promotes healing.

Below, we've outlined the Code of Conduct and Expectations for all Patients and Visitors designed to help make your hospital stay, appointment, or visit successful:

- Patients, visitors, and staff will address each other in a respectful manner.
- Patients, visitors, and staff will respect patient privacy and Protected Health Information (PHI) policies, and comply with requirements of the Health Insurance Portability and Accountability Act (HIPAA).

- Patients, visitors and staff will refrain from exhibiting threatening or abusive behavior towards each other. We have a zero tolerance policy for threatening or abusive behavior.
- Profanity, racial or cultural slurs or other derogatory remarks toward others of any kind is not tolerated. This includes, but is not limited to: Slurs or remarks targeting another's age race, ethnicity, religion, culture, disability, language, sexuality or sexual orientation, gender identity, socioeconomic states, marital status, or ancestry.
- Weapons, illegal or dangerous items, alcohol, marijuana, and illicit drug use, as well as possession of related paraphernalia, is forbidden in all areas and campus grounds.
- Patients and visitors are not allowed to record audio, video, or take photos in any clinical area, or in non-clinical areas where staff or patients may be captured, without their explicit consent.
- Patients are encouraged to speak with their providers about their therapeutic care plan.
- This is a smoke-free campus. Tobacco use is forbidden on campus grounds.

The Following Expectations are also Required of All Hospitalized or Clinic Patients:

- Patients will remain on the unit for their safety, and to facilitate timely care. Being on the unit allows for prompt testing, timely medication administration and frequent assessment by healthcare providers. Leaving the unit may be considered leaving against medical advice and could result in your discharge.
- Patients are responsible for providing correct and complete information about their health and past medical history. Patients are responsible for reporting changes in their general health condition, symptoms, or allergies to the responsible caregiver.
- Patients are responsible for assisting in the control of noise in their rooms and complying with system visitation guidelines.
- Patients are expected to attend appointments as scheduled. If you are not able to attend an appointment, you or another person must give ample notice to the department or office in which the visit is scheduled. Freeman Health System may dismiss patients from a specific department or health care provider due to behaviors such as:
    - Repeated missed appointments without proper cancellation, in advance
    - Failure to follow an agreement related to the use of controlled substance(s) or similar concerns.
    - Failure to follow the care team's treatment plan, a treatment plan is also called a "care plan."

A safe and respectful environment is central to promoting a healing environment; therefore, if the above-mentioned expectations are not followed:

Patients: If you choose not to comply with your therapeutic care plan or the above expectations, we may discharge you from the hospital or your appointment. For subsequent appointments or admissions, we will follow our standard continuity of care practice and seek to have you cared for by the same care team.

Visitors: If you fail to comply with the above expectations, you may be asked to leave campus and may be restricted from future visitation privileges.

Failure to comply with Freeman Health System Code of Conduct for Patient and Visitor Behavior and other applicable rules may result in additional action by Freeman Health System. These additional actions may include, but are not limited to:

- The presence of Freeman Health System Security staff during patient appointments and any other interactions with Freeman Health System staff.
- Involvement of local law enforcement.
- Prosecution for trespassing or criminal behavior, or both.

PATIENT SAFETY

During your stay at Freeman Health System, we'll strive to give you the best possible care.

FREEMAN Health System

BE CAREFUL NOT TO FALL

Call a nurse before attempting to get out of bed. Get up slowly and wear non-skid socks, slippers, or other slip-resistant footwear. Clear an obstacle-free path that gives you plenty of room to move freely.

PROTECT YOUR SKIN

To prevent bedsores, safely adjust your position in bed frequently, and move as much as you're safely able to do so. Check your skin each day, and keep it as clean and dry as possible.

WASH YOUR HANDS

Clean hands help lower the risk of infection. Your visitors and those who care for you at home should also wash their hands or use hand sanitizer often.

GET MOVING

Ask your nurse how soon you can safely get out of bed. While lying down, move your legs and ankles, and ask your doctor about devices that keep blood flowing through your legs and feet.

DON'T SMOKE

Non-smoker patients recover more quickly. If you smoke, ask your doctor for help with quitting. This is a great time to quit!

TAKE YOUR MEDICATION

It's important to take your medication exactly as your doctor has instructed. Be mindful of side effects, and speak up if you experience any adverse effects or reactions.

SPEAK UP IF YOU'RE IN PAIN

Let someone know if you're experiencing pain or side effects from medication. Pay close attention to how you feel, and let us know.

Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement: Discrimination is Against the Law

Freeman Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

Freeman Health System does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Freeman Health System:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact an Admissions representative, your nurse, or Freeman Health System Patient Relations Department.

If you believe Freeman Health System has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Freeman Health System, Director of Risk Management and Patient Relations at 1102 W. 32nd Street, Joplin, MO 64804. *417.347.4940* [Phone], *417.347.3610* [Fax], Freeman Contact Us | Freeman Health System (f*reemanhealth.com/contact-us*) [Website]. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Freeman Health System Director of Risk Management and Patient Relations 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 *ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at *hhs.gov/ocr/office/file/index.html.*

You can also file a civil rights complaint with the Missouri Department of Social Services, Office for Civil Rights by mail or phone at: Department of Social Services, Office for Civil Rights, P.O. Box 1527, Jefferson City, MO 65102, *800.776.8014* [Phone], or *866.735.2460* [Voice]; *800.735.2966* [Text]

This notice is available at Freeman Health System website: Patients and Visitors | Freeman Health System Freeman Health System [URL]: *freemanhealth.com/patients-and-visitors#964037043-2655426705*

Language Assistance

Language assistance is provided free of charge. Please contact an Admissions representative or nurse if you are in need of language assistance.

Language Assistance Services for Individuals with Limited English Proficiency

1. **(English)** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 417-347-1111 (TTY: 1- 800-682-8786).
2. **(Spanish)** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 417-347-1111 (TTY: 1- 800-682-8786).
3. **(Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 417-347-1111（TTY：1- 800-682-8786）。
4. **(Vietnamese)** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 417-347-1111 (TTY: 1- 800-682-8786).
5. **(Serbo-Croatian)** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 417-347-1111 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-682-8786).
6. **(German)** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche ilfsdienstleistungen zur Verfügung. Rufnummer: 417-347-1111 (TTY: 1- 800-682-8786).
7. **(Arabic)** مقرب لصتا .ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ :ةظوحلم
   1111) مقر .(800 -682-8786- 1 :همصلا مكبلاو
8. **(Korean)** 주주: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 417-347-1111 (TTY: 1- 800-682-8786)번으로 전화해 주십시오.
9. **(Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 417-347-1111 (телетайп: 1- 800-682-8786).
10. **(French)** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 417-347-1111 (ATS: 1- 800-682-8786).
11. **(Tagalog – Filipino)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 417-347-1111 (TTY: 1- 800-682-8786).
12. **(Pennsylvanian Dutch)** Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 417-347-1111 (TTY: 1- 800-682-8786).
13. **(Persian (Farsi))** هجوت :امش یارب ناگیار تروصب ینابز تالیهست ،دینک یم وگتفگ یسراف نابز هب رگا
    .سامت دیریگب 417-347-1111 (TTY: 1- 800-682-8786) .اب مهارف یم دشاب

14. **(Oromo)** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 417-347-1111 (TTY: 1- 800-682-8786).
15. **(Portuguese)** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 417-347-1111 (TTY: 1- 800-682-8786)
16. **(Amharic)** ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 417-347-1111 (መስማት ለተሳናቸው: 1- 800-682-8786).
17. **(Cherokee)** Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 417-347-1111 (TTY: 1- 800-682-8786)
18. **(Micronesian-Pohnpeian)** Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 417-347-1111 (TTY: 1- 800-682-8786).
19. **(Laotian)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າ ພາສາ ລາວ, ການບໍ ລິການຊ່ ວຍເຫຼືອ ດ້ ານພາສາ, ໂດຍບໍ ່ເສັ ງຄ່ າ, ແມ່ ນມີ ພ້ ອມໃຫ້ທ່ ານ. ໂທຣ 417-347-1111 (TTY: 1- 800-682-8786).
20. **(Japanese)**注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。417−347−111（TTY:1-800-682-8786） まで、お電話にてご連絡ください。
21. **(Hmong)** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 417-347-1111 (TTY: 1- 800-682-8786).
22. **(Swahili)** KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 417-347-1111 (TTY: 1- 800-682-8786).
23. **(Thai)** เรียน: ถ้ าคุณพูดภาษาไทยคุณสามารถใช้ บริการช่ วยเหลือทางภาษาได้ ฟรี โทร 417-347-1111 (TTY: 1- 800-682-8786).
24. **(Urdu)** خبردار: اگر آپ اردو بولتے ہیں، تو زبان کی مدد تک مفت رسائی حاصل کر سکتے ہیں۔ کال کریں 417-347-1111 (TTY: 1- 800-682-8786).
25. **(Burmese)** သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 417-347-1111 (TTY: 1-800-682-8786) သို့ ခေါ်ဆိုပါ။

Freeman Health System Financial Assistance Program

The Freeman Health System Financial Assistance Program exists to provide eligible patients with partially or fully discounted emergent or medically necessary care. Patients seeking financial assistance must apply for the program.

ELIGIBILITY:

Freeman offers financial assistance for eligible patients receiving emergent or medically necessary care at Freeman hospitals or clinics. Services must be billed by Freeman to qualify. Some external services, such as pathology, may be eligible—patients should contact those providers directly.

To qualify, patients must have received eligible services, submitted a completed Financial Assistance Application with all required documentation, and been approved by Freeman.

HOW TO APPLY:

Patients may download the Financial Assistance Application at *freemanhealth.com*, where the form is editable. Applicants can enter their personal information, save the completed form to their device, and email it—along with all required documentation—to our Eligibility Partners at *freemanfinancialassistance@freemanhealth.com*.

Alternatively, you may request an application at any main registration desk within Freeman hospitals or clinics. Applications are also available in person at the Freeman Patient Accounts Department, located at 3220 McClelland Boulevard, Joplin, Missouri. You may contact the department by phone at *417.347.6686* or submit a written request.

If mailing, send the completed application with all documentation and information specified in the instructions to: Freeman Health System: **Patient Accounts** 1102 W. 32nd St. Joplin, MO 64804

DETERMINATION OF FINANCIAL ASSISTANCE ELIGIBILITY:

Patients may qualify for financial assistance. Discounts are offered for financial assistance up to 100 percent, for those who qualify. Please find application and current financial assistance policy on our hospital website. Freeman reviews completed applications in accordance with its Financial Assistance Policy. Incomplete applications will not be processed, but applicants will be notified and given a chance to provide missing information.

Need help? Have questions?

For questions about *Price Transparency*, requesting a *Good Faith Estimate*, or understanding protections under the *No Surprises Billing Act*, please visit freemanhealth.com.

You may also contact Freeman Patient Accounts at *417.347.6686*, Monday through Friday, 8:00 am to 4:30 pm, to speak with an account representative.

Advance Medical Directives and Durable Power of Attorney for Health Care

Advance Medical Directives: Protecting Your Rights

Advance medical directives (AMD) safeguard your rights in the event that you become mentally or physically unable to make or communicate decisions about your medical treatment. As a competent adult, you have the right to accept or refuse medical care.

What is a Durable Power of Attorney for Healthcare?

A Durable Power of Attorney for Health Care (DPOA) is a written document in which you designate a person (or persons) to act as your agent or proxy to make health care decisions on your behalf if you become unable to do so. You may also include your wishes regarding organ, bone, or tissue donation for transplantation in the event of your death. To be valid, this document must be signed and either notarized or witnessed:

In Kansas, your signature must be notarized or witnessed by two individuals.
In Missouri, your signature must be notarized.

It is Freeman Health System's mission to support a patient's right to participate in making decisions about their health care. Freeman Staff members provide patients and families with information about advanced health care instructions, health care treatment directives, and durable powers of attorney for health care.

Notary Service

This service is only for health care-related documents, such as advanced directives and durable power of attorney for health care.

- An advance directive indicates what should be done if you are no longer able to make decisions.
- A durable power of attorney for health care lets you name a person to make decisions about your health if you cannot make them yourself.
- Please give a copy of your completed directive to your nurse so it can be placed in your medical record. Your wishes cannot be honored until a physical copy is available.
- We will provide you with information to create an advance directive if you don't have one and want one.
- Our policy is to honor your advance directive within the limits of the law and mission of Freeman Health System, with a few exceptions.
- If you have a *Do Not Resuscitate* (*DNR*) Directive, it will be placed on hold during surgery or procedures.

Please Note: Advance medical directives do not take effect while you are still able to communicate your wishes regarding health care treatment. Review your directives regularly and update them as needed. Inform your physician, family, and designated agent of any changes. You may revoke or revise your directive at any time, either orally or in writing. Freeman will honor your wishes as stated in a properly executed document.

Need Assistance? If you need assistance in completing this document, you may contact these offices from 8:00 am to 4:30 pm or ask for your nurse.

- **Joplin Hospital Campus:**
  - Freeman Health System, Patient Liaisons *417.347.6677*
  - Freeman Health System, Social Services Department *417.347.6614*
- **Neosho Hospital Campus:**
  - Freeman Neosho Hospital, Social Services Department *417.347.4304*
  - Freeman Neosho Admissions, *417.347.4346*
- **Ft Scott Hospital Campus:**
  - Freeman Fort Scott Admissions, *620.768.0391*

Transportable Physician Orders for Patient Preference (TPOPP) Kansas—Missouri

TPOPP is appropriate for patients who have a serious, progressive and chronic illness and have talked with trusted health care providers about the type of medical care they want as their disease and symptoms worsen. It addresses a person's thoughts on CPR, medical care, and artificial nutrition. The TPOPP form is bright pink, signed by a doctor and, directs future medical care. Use of TPOPP is completely voluntary.

TPOPP is practical and can be taken into different healthcare settingssuch as: a hospital, home, hospice, or nursing facility.

Important notes: If a physician, nurse, or other health care provider morally feels that he/she cannot follow the wishes expressed in the advance medical directive, and the advance medical directive is within state and federal law, it is the responsibility of the physician and hospital to help the patient find a health care provider, physician, nurse, or hospital that will follow the patient's advance medical directive.

Individuals shall not be discriminated against because of their advance medical directive.

Advance Medical Directive
including Durable Power of Attorney for Health Care

When selecting your health care agent, choose someone who knows you well. It should be someone you trust and who respects your views and values. This person should be able to make difficult decisions under stress. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person(s) you choose to be your health care agent(s).

A health care agent must be at least 18 years old. Your health care agent may not be one of your health care providers, or an employee of your health care provider, unless he or she is a close relative.

This document **does not** give your health care agent authority to:

- Make financial or other business decisions.
- Make certain decisions about your mental health treatment.

To complete this advance directive

This advance directive is divided into three parts:
Part 1 – My health care agent
Part 2 – Statement of desires, care institutions or limits
Part 3 – General Provisions
Follow the instructions in each of the three parts.

FREEMAN Health System

DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE[1] OF

(Print full name here) _____

(Address, City, State, Zip) _____

I make this Durable Power of Attorney and/or Healthcare Directive to exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions when I lack the capacity to make or communicate my decisions. It is my intent that this document to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others.

PART 1. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(If you *DO NOT WISH* to name someone to serve as your decision-making Agent, mark an "X" through Part I on pages 1 & 2 and continue on to Part 2.)

1. Selection of Agent.

I, (your name printed) _____ **DOB:** _____ currently a resident of _____ County, _____ (State), appoint the following person as my true and lawful attorney-in-fact of ("Agent"): **Name:** _____

Address: _____

_____

Phone(s): 1st _____ 2nd _____

2. Alternate Agent. If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following persons in the order named below to serve as my alternate Agent and to have the same powers as my Agent:

First Alternate Agent:

Name: _____

Address: _____

_____

Phone: _____

Second Alternate Agent:

Name: _____

Address: _____

_____

Phone: _____

3. Durability. This is a Durable Power of Attorney, and the authority of my Agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

4. Effective Date as to Health Care Decision Making. This Durable Power of Attorney is effective as to health care decision making when I am incapacitated and unable to make and communicate a health care decision as determined by my physician.

5. **Agent's Powers**. I grant to my Agent full authority as to health care decision making to:

a. Give consent to, prohibit, or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, either in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out of hospital do-not-resuscitate order, with the following specific authorization ***(check one of the following boxes to indicate your choice):***

☐ I **wish to AUTHORIZE** my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

☐ OR I **DO NOT AUTHORIZE** my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

b. Make all necessary arrangements for health care services on my behalf and to engage or terminate medical personnel responsible for my care.
c. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent.
d. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care.
e. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my "personal representative" as defined in the regulations [45 C.F.R.164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

6. **Effective Date as to other Authority**. In addition to the powers set forth above, I authorize effective upon my signature and without the need for a physician's certification of incapacity that my Agent be authorized to have one or more of the following powers (**check your desired choices):**

☐ Determine what happens to my body after my death (authority for right of sepulcher).

☐ Give consent after my death to an autopsy or postmortem examination of my remains.

☐ Delegate health care decision-making power to another person ("Delegee") as selected by my Agent, and the Delegee shall be identified in writing by my Agent.

With respect to **anatomical gifts of my body** or any part (i.e., organs or tissues), please initial your desired choice below:

☐ **AUTHORIZATION OF ANATOMICAL GIFTS. I wish to AUTHORIZE my Agent** to make an anatomical gift of my body or part (organ or tissue).

My donations are for the following purposes: (check your desired choices):	**GIFT SPECIFICATIONS:** I would like to donate (check your desired choices):
☐ **Transplantation**	☐ **Any needed organs and tissues, as allowed by law.**
☐ **Therapy**	☐ **Any needed organs and tissues as allowed by law, with the following restrictions:**
☐ **Research**	
☐ **Education**	
☐ **All the above**	

☐ **PROHIBITION OF ANATOMICAL GIFTS. I DO NOT AUTHORIZE my Agent** to make an anatomical gift of my body or any part (organ or tissue)

PART 2. HEALTH CARE DIRECTIVE

(If you DO NOT WISH to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part 1 on pages 1 & 2, mark an "X" through Part 2 on pages 2 & 3 and continue to Part 3.)

1. I make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.
2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that the life-prolonging procedures that I have initialed below be withheld or withdrawn:
   a. ☐ **Artificially supplied nutrition and hydration**
      (including tube feeding of food and water)
   b. ☐ **Antibiotics**
   c. ☐ **Surgery or other invasive procedures**
   d. ☐ **All other "life-prolonging" medical or surgical procedures**
      (that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury)
   e. ☐ **Heart-lung resuscitation (CPR)**
   f. ☐ **Dialysis**
   g. ☐ **Mechanical ventilator (respirator)**
   h. ☐ **Chemotherapy**
   i. ☐ **Radiation therapy**
   j. ☐ **Other procedures specified by me:** _____
      (Please describe)
3. However, if my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me or my Agent to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or may breathing, or be habit forming.
4. If I have chosen to not have life-prolonging procedures (any and all of the boxes above having been checked), (please check one of the following boxes): ☐ I DO WANT or ☐ I DO NOT want palliative care; hospice care; medication for anxiety, pain, and/or discomfort; ice chips; mouth swabs; and any other measures to keep me comfortable.
5. If I have already consented to be on the applicable State organ and tissue donor registry or my Agent has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, PART II OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE

PART 3. GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

1. **Relationship Between Durable Power of Attorney for Health Care and Health Care Directive.** If I have executed both the Durable Power of Attorney for Health Care and Health Care Directive, I encourage my Agent to:
   a. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.
   b. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for himself or herself.*

c. Third, if my Agent has little or no knowledge of choices I would make, then my Agent and the physicians will have to make a decision based on what a reasonable person in the same situation would decide. I have confidence in my Agent's ability to make decisions in my best interest if my Agent does not have enough information to follow my preferences.

d. Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if my Agent is not able to serve, the Health Care Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

2. **Protection of Third Parties Who Rely on My Agent.** No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

3. **Revocation of Prior Durable Power of Attorney for Health Care or Health Care Directive**. I revoke any prior living will, declaration or health care directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any prior health care durable power of attorney, or any health care terms contained in that other durable power of attorney and intend that this Durable Power for Attorney for Health Care (if completed) and this Health Care Directive (if completed) replace or supplant earlier documents or provisions of earlier documents.

4. **Validity.** This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original**.**

IF YOU HAVE COMPLETED THE ENTIRE DOCUMENT OR ONLY THE DIRECTIVE (PART II), YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES.

IN WITNESS WHEREOF, I signed this document on _____ (month, date), _____(year).

Signature: _____

Printed Name: _____

WITNESSES: The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen years of age.

Signature: _____ Signature: _____

Print Name: _____ Print Name: _____

Address: _____ Address: _____

NOTARY ACKNOWLEDGMENT

(Only required if Part 1 or entire document completed.)

STATE OF _____ **)**
)SS
COUNTY OF _____ **)**

On this _____ day of _____(month), _____ (year), before me personally appeared _____ _____, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County or City and state aforementioned on the day and year first above written.

_____
Signature

_____, Notary Public
(Name Printed)