



The regulations below MUST be agreed on prior to being seen by a provider. If there is a regulation that you do not agree with, we unfortunately will not be able to proceed with seeing you.

PLEASE INITIAL EVERY REGULATION AND SIGN AT THE BOTTOM

We thank you very much for choosing our office. It is a great privilege to be able to serve you and take part in your health care needs. We will always strive to meet your expectations and to provide you with the best medical care possible.

Please carefully review and initial the following rules and regulations related to our office. Please always try to follow these regulations as they are intended to make the workflow in our office more efficient and practical. If you have any questions about these rules, please do not hesitate to ask one of our office staff members.

_____ 1) During your visit, you will be seen by any of our providers depending on who is available. Due to the type of care, we provide, a provider may be called to cover the hospital patients and may not be available. You may be seen by a different covering provider. All of our providers are licensed and highly qualified. You have a team of providers taking care of you, not just one person.

_____ 2) If you have been waiting in the waiting area and not called into an exam room for more than 30 minutes, please alert the front desk immediately. Our goal is to cut down your wait in the lobby as much as possible.

_____ 3) Copays, deductibles, and coinsurances are expected to be paid fully at the time of visit.

_____ 4) Please get all of your prescriptions during your office visit. Please make sure the prescription that you receive will last until your next appointment.

_____ 5) If you need prescription refills in between office visits, please contact your pharmacy and ask them to send us an electronic refill request. The pharmacy may take several days for them to contact us. Please allow one week for this to be completed.

_____ 6) We do not provide any results over the phone due to HIPAA laws. Please do not call asking for the results. They will be discussed with you during your next office visit.

_____ 7) Please note that the labs and other results, such as radiological studies, are reviewed only during an office visit. Anytime you have a test completed, please make sure that you have an appointment to go over the results. If you for some reason do not show up for an appointment and have abnormal results, it will not be the office's responsibility to review those labs or to contact you regarding them. As mentioned above, all labs and radiological studies are reviewed during the office visit only. It is your responsibility to have an office visit to discuss your results.

_____ 8) Please allow 7-10 business days to process any request for medical records. There is a charge for copying medical records of \$1.00 per page for the first 25 pages, then \$0.25 per page after that. If you are picking up medical records, you must bring a valid ID. If you send someone to pick up patient records, they must be listed on the patients Authorization to Release Medical Records and must bring their valid ID and a copy of the patient's ID.

_____ 9) Forms: The cost to fill out forms is \$35 for 1 page, the \$20 per each additional page. Example: 4 pages - \$35+\$20+\$20+\$20=\$95. Writing a letter for a patient will be \$75. School forms for children are excluded from the above fee. Please note this may take 7-10 business days.

_____ 10) I will treat the staff and the providers with respect. I understand that the office has a zero-tolerance policy for abnormal or disrespectful behavior.

_____ 11) For patient safety, it is not advised to give medical advice over the telephone without examination and taking proper detailed history. Therefore, if you call during business hours with any symptoms, we will ask you to come to the office that day. If you have a medical question, please come to the office to receive your answer. If you forget what the doctor or nurse practitioner told you during your office visit, please come to the office as we cannot discuss this over the phone. If you want your prescription changed to a different medication, please come to the office. We cannot do this over the phone. If you need to leave a message for the doctor, nurse practitioner, or nurse, please allow 1-2 business days for a returned phone call. If you have any questions or concerns, please do not hesitate to write your suggestion to Dr. Kamel or to talk to anyone of the office staff. It is a great pleasure and honor to be able to serve you and we hope you will have an outstanding experience in our office that meets your expectations.

_____ 12) We have a remote monitoring program and chronic care program that may contact you on behalf of our practice. Participating in these programs is voluntary. You agree that you may be contacted for the above service unless you decline them. You also agree that you will be responsible for your portion of copay, deductible, and coinsurance for these services.

_____ 13) You agree to download the free healow app. You agree that the Healow app is the preferred way of communicating with our office for any reason except emergencies. For emergencies, please call 911.

I agree to follow the above regulations.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____



PATIENT INFORMATION PACKAGE

Name: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email address: _____

Primary language: English Spanish Other: _____ Ethnicity: Hispanic Non-Hispanic

Race: Native American Asian Indian Black/African American Chinese Japanese Korean White

Other: _____

Gender: Male Female

Social Security Number: _____ Choice of Contact Phone Email

Spouse: _____ Date of Birth: _____

Who is responsible for this account: _____ Relationship to Patient: _____

Do you have Medical Insurance: Yes No Name of Insurance company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Number: _____ Group Number: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

Pharmacy Name and Address: _____

Please fill out all areas asked. If you have a list of your medications, surgeries, and past medical history, please hand it to the front desk during check-in.

Reason for your visit: Please list your chief complaints or concerns

1. _____
2. _____
3. _____

Social History

Marital status: Married Single Widowed Divorced Partnered

Living Arrangement: Live Alone Live with others

Live with whom? _____ Where? House Assisted Living Facility Retirement Facility

Children: How many? _____ Ages: _____

Medications: Please list all of your medications including prescriptions, over the counter and herbal supplements

Name of Medication	Dosage	How many times a day?

Medication Allergies: Please list all medication allergies and medications you have tried in the past that did not work for you.

Medication	Reaction

Other Allergies: Please list any food allergy or environmental allergy such as latex, dyes, tapes, etc.

Allergy	Reaction

List all doctors or health care providers you are currently seeing

Name of Doctor	Specialty/Area of Practice

Review of Systems: Please circle if you have recently had problems with any of the following.

General: Weight Gain: How much: _____ Over how long: _____

Weight Loss: How much: _____ Over how long: _____

Fatigue, Fever, Night sweats, Heat or cold intolerance, Loss of appetite or Increased appetite

Skin: Rash, Hair loss, Easy bruising, Toenail infection, Dark lines in the skin, Acne, Ulcers

Eyes: Blurry vision, Excessive tears, Redness, Pain, Discharge, Dryness, Visual changes

Nose: Nose bleed, Nasal discharge/drainage, Sinus pain, Sinus congestion

Ears: Ear pain, Ear discharge, Change in hearing, Sudden hearing loss

Mouth: Oral lesions, White patches, Bleeding gums, Toothache

Throat: Hoarseness, Sore throat, Pain when swallowing, Difficulty swallowing, Lump in throat, Tender lymph nodes

Respiratory: Cough, Coughing blood, Shortness of breath at rest, Shortness of breath on exertion, wheezing

Cardiovascular: Chest discomfort, Palpitations (heart fluttering or racing), Ankle swelling, fast heartbeat, Difficulty breathing when laying down, Awakening short of breath

Urinary: Pain with urination, Urinating frequently, Incontinence (losing your urine) with coughing/laughing, Urinating before you can get to the bathroom, Urination at night, Difficulty starting a urine stream, Blood in urine, Urinating large amounts

Gastrointestinal: Nausea/Vomiting, Diarrhea, Blood in the stool, Black tarry stool, Heartburn/Reflux, Constipation

Sexual: Difficulty achieving and maintaining an erection, Decreased libido

Musculoskeletal: Joint pain or stiffness: Which joints? _____

Joint swelling or redness: Which joints? _____

Back pain, Muscle pain, Rings on finer becoming tighter and/or increasing in size

Neurological: Difficulty with memory, Fainting/Losing consciousness, Weakness (which part of the body): _____, Seizures, Sever or frequent headaches, Difficulty with balance, difficulty walking, Lightheadedness, Vertigo (world spinning around you)

Psychological: Depresssion, Lack of interest in and enjoyment of activities that previously brought pleasure/fulfillment, Decreased sense of self-worth, Difficulty focusing and concentrating, Desire to end your life, Disabling anxiety, Panic attacks

Endocrine: Excessive facial hair, Breast discharge, Irregular Menses, Prolonged Menses, Complete loss of Menses, Hot/Cold intolerance

Hematologic/Lymphatic: Enlargement of lymph nodes, bleeding, pallor

Immunologic/Allergic: Hives, itchy skin, Seasonal allergies

Sleep: Difficulty getting to sleep, Difficulty staying asleep, Snoring, Cessation of breathing during sleep (as reported by bed partner), Napping during the day

Health maintenance: Please provide us with the most recent information regarding the following.

Date of your most recent Cholesterol check: _____

Have you received a Tetanus vaccine booster? Yes No Date: _____

Have you received the Shingles vaccine? Yes No Date: _____

Have you received the Pneumovax (pneumonia vaccine)? Yes No Date: _____

Have you received the Flu vaccine this flu season? Yes No Date: _____

Have you had a skin cancer screening performed by a dermatologist? Yes No Date: _____

Have you had a colonoscopy? Yes No Date: _____ Normal? Yes No

Have you had a bone density test? Yes No Date: _____ Results: _____

For women: When was your last mammogram: _____ Normal? Yes No

When was your last Pap smear: _____ Normal? Yes No

Have you had a hysterectomy? Yes No Date: _____ Reason: _____

For men: When did you have your last digital rectal exam? _____ Normal? Yes No

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Notice of Privacy Practices of Institute of Endocrinology

This notice describes:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION
- YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH [ENTER NAME OR TITLE] AT [PHONE AND EMAIL] IF YOU HAVE ANY QUESTIONS.

In this notice, your health information means your substance use disorder patient record.

Your Rights

You have the right to:

- Consent to most uses and disclosures of your health information
- Ask us to limit the information we share
- Get a copy of this privacy notice
- Discuss this notice with someone in our program
- Get a list of those with whom we've shared your electronic records^o
- Get a list of health care providers who have received your information through certain third parties
- Choose in advance whether to receive fundraising communications
- File a complaint if you believe your privacy rights have been violated

Your Choices

With your consent, we can use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Fulfill your requests to share information with your consent
- Prevent multiple program enrollments
- Report about court-referred treatment
- Report to prescription drug monitoring programs

Our Uses and Disclosures

We may use and share your information without your consent as we:

- Communicate within our program and with our contractors
- Help with medical emergencies

- Help with public health
- Report crimes (and threats of crimes) on our premises and suspected child abuse and neglect
- Aid scientific research
- Respond to audits and evaluations of our program
- Assist cause of death inquiries
- Respond to court orders

In all these circumstances, we must protect your information and limit how we use and share it.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Provide consent when we use or share your information for most purposes

- You may provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes. We are not required to agree to your request, and we may say “no” if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our health care operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose in advance about fundraising

You have the right to a clear and obvious notice in advance of, and a choice about whether to receive, fundraising communications for our program.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services’ Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.
- We will not retaliate against you for filing a complaint.

Your Choices

How do we typically use or share your health information?

With your consent, we typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications.

Run our organization

We can use and share your health information to run our program, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

With your consent, we may also use and share your information in the following ways:

- To whomever you name in a consent to share your information
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs
- To report participation in treatment required by the criminal justice system
- To report prescribed substance use disorder treatment medications to a state prescription drug monitoring program when required by law

You can choose someone to act for you.

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in certain ways without your consent – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

To communicate within our program and with contractors

We can share your information within our program, with an organization that has administrative control over our program, and with contractors who help us run our program.

For medical emergencies

We can share your information during a bona fide medical emergency with the personnel and health care providers responding to your emergency, even when you are unable to consent because of the emergency.

We can also share your identifying information to assist the federal Food and Drug Administration in notifying you or your doctor about unsafe products you may be using.

Help with public health

We can share health information that does not identify you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications

Aid scientific research

We can use or share your information to conduct or help with health research. Researchers cannot include any patient identifying information in their reports about the research.

Respond to management and financial audits and program evaluations

We can use or share your information to improve the quality of our services, obtain needed credentials, and cooperate with oversight agencies for activities authorized by law, as long as those who view or receive the information agree to destroy or return the information when they are finished and agree not to use it against you.

Assist with cause of death inquiries

We can share patient identifying information about a deceased patient as required or allowed by laws that collect information relating to cause of death.

Report suspected child abuse and neglect

We will only report the information required by law.

Prevent or reduce crime in our program

We may report to law enforcement when a patient commits or threatens to commit a crime within our program or against our staff.

Redisclosure According to HIPAA

When you consent to uses and disclosures for all future treatment and payment purposes and to run our business, we may share your information with other substance use disorder treatment programs, doctors' offices, and health care businesses for those activities. If the person who receives it is subject to HIPAA, then they are allowed to use and share your information again without your consent for the purposes that HIPAA allows. Your information still cannot be used in legal proceedings against you unless (1) you consent or (2) based on a Part 2 court order and a subpoena (or similar legal requirement).

Legal Proceedings and Court Orders

We must follow certain procedures before using or sharing your information for investigations and legal proceedings.

- We will not use or share your information or provide testimony about your information in any civil, administrative, criminal, or legislative proceedings against you without your written consent or a court order.
- We will only respond to a court order to use or share your health information if it is accompanied by a subpoena or other similar legal mandate requiring us to comply.
- We will only use or share your information in proceedings against you based on a court order after we have received notice and an opportunity to be heard or you tell us that you have received notice.
- We may use or share your information to respond to legal proceedings against our program based on a court order and you may not be notified in advance. You have the right to seek to overturn or change the court order after you learn about it.

Our Responsibilities

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your information.
- We must let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We are required to follow the terms of this notice that are currently in effect. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our web site.

Effective Date

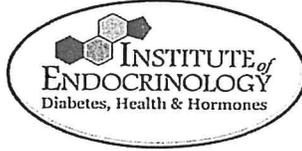
This notice is effective as of March 10th, 2026.

Other Instructions for Notice

- Our privacy contact is Dr. Sherief Kamel, 850 522 5490, email sherief.kamel@iedhh.com.
- We will provide you with a summary of your treatment history upon request.
-

Name _____ Todays Date _____

Signature _____ DOB _____



AUTHORIZATION TO RELEASE INFORMATION

THE FOLLOWING PEOPLE NAMED BELOW MAY OBTAIN MEDICAL INFORMATION FOR ME AND MAY SPEAK FOR ME IF I WAS TO BECOME UNABLE TO EXPRESS MY WISHES.

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES (HIPPA) AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Patient's Name: _____ **DOB:** _____

Patient's Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL.

I HEREBY AUTHORIZE IEDHH TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIM OR HIS ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO IEDHH OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I CERTIFY THAT THE INFORMATION THAT I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

Patient's Name: _____ **DOB:** _____

Patient's Signature: _____ **Date:** _____

I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

Patient's Name: _____ **DOB:** _____

Patient's Signature: _____ **Date:** _____



Authorization to Obtain, Release or Review Protected Health Information (PHI)

Patient Name: _____ DOB: _____

I hereby consent IEDHH employees' access to my personal health information (PHI), including laboratory test and progress notes, from any lab/hospital with a portal. I authorize the release of my records to IEDHH for review and acknowledge that I am the patient associated with this account. I also consent for IEDHH employees to obtain and review my medical records through Prisma. By obtaining and reviewing my medical records, my provider will be able to make better decisions when it comes to my medical care. I understand that my information will be protected under applicable privacy laws and will only be used for personal health care purposes.

Information to be obtained from:
Name of organization:
Phone Number:
Fax Number:

Signature: _____ Date: _____

I hereby grant IEDHH and its employees' permission to release my personal health information (PHI) to the organization, as listed below.

Information to be released to:
Name of organization:
Phone Number:
Fax Number:

- | | |
|---|---|
| <input type="checkbox"/> Most recent progress notes | <input type="checkbox"/> All ultrasound and radiology reports |
| <input type="checkbox"/> All progress notes | <input type="checkbox"/> Psychiatric/Psychological reports |
| <input type="checkbox"/> All laboratory reports | <input type="checkbox"/> HIV/AIDS test results |
| <input type="checkbox"/> Other (Please specify) _____ | |

Please specify anything you do NOT want to be released: _____

Purpose of release:
 Continuing care Specific request: _____

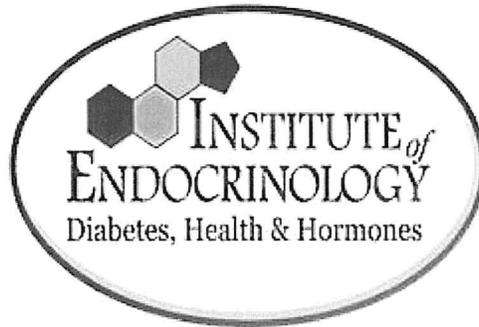
Authorization & Acknowledgment I understand this authorization is voluntary and may be revoked at any time by written notice, except to the extent action has already been taken in reliance on it. I understand that once my records are disclosed, they may no longer be protected by federal privacy laws. Unless otherwise specified, this authorization will remain valid for 12 months from the date of signature. I understand that medical providers are allowed by Florida law (§456.057, F.S.) to charge reasonable fees for copying and mailing records.

I understand that this authorization extends to all, or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or HIV/AIDS test results. I expressly consent to the release of the information designated above.

I understand that this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law.

I understand that after signing this form, there is a processing period for records requests of 7-10 business days and may be subject to a processing fee of \$1.00 per page for the first 25 pages and \$0.25 for pages 26+. The processing fee does not apply to records being sent directly to a healthcare provider.

Signature: _____ Date: _____



LABORATORY AND RADIOLOGICAL TESTING ACKNOWLEDGEMENT

The practice will usually order diagnostic tests (laboratory or radiological tests) based on your clinical case and your medical complaints in order to make a diagnosis and establish a treatment plan.

You must understand that not every test we may order or consider important to you will necessarily be covered and/or paid for by your insurance. It is your responsibility as the patient to check with your insurance to see if they cover and pay for the test or study based on your diagnosis.

Please check with your insurance about coverage before every lab or radiological test you undergo. Again, it is not the responsibility of the office in the event that your insurance does not cover a certain test or service.

Patient's Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____



BILLING POLICIES

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

On arrival, please sign in at the front desk and present your current insurance card. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your behalf.

IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurance at the time of the visit. **YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.**
2. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if pre-authorization is required prior to a procedure, and what services are covered.
3. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
4. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
6. If previous arrangements have not been made with our finance office, any balance over 60 days will be forwarded to a collection agency.
7. A \$20.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
8. It is your responsibility to know if a selected specialist participates in your plan.
9. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
10. You agree to pay a **\$75.00 No-show fee** if you do not show up for your appointment and did not call to cancel or reschedule at least 24 hours prior to your appointment.

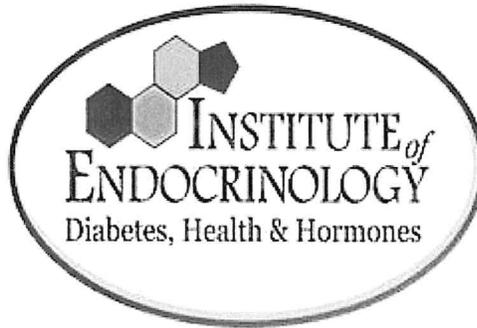
Patient Name _____

Responsible Party Member's Name

Relationship

Responsible Party Member's Signature

Date



Today's Date: _____

Patient's Name: _____

Patient's DOB: _____

Advance Directives:

Do you have written advance directives?

_____ Yes

_____ No

_____ I am unsure

Code Status:

In the unexpected and rare case of a code (heart or respiration stops), what option would you prefer?

_____ Full code, including doing chest compression and cardiac shock if needed.

_____ Do not resuscitate, meaning no cardiac shocks or assisted breathing
(If you select this option, you must fill out a DNR form)

_____ I have not decided at this time.

Patient/ Guardian's signature