October 18, 2022

Behavioral Health Program Update,

We would like to contact you by email, but we know that email is not private and we are committed to protecting your information. To ensure confidentiality, Four Winds - Saratoga uses an encrypted email service through Proofpoint Inc. Communication can be through this service or by phone. Please do not use email to communicate regarding clinical emergencies.

If you choose to email, your emails sent to phpiop@fourwindssaratoga.com will be received by a member of the Behavioral Health staff. If you receive an email from a member of our staff, you will receive a notification message in your email inbox. That message will include instructions on how to open the message.

You should:

- Register the first time you receive an email from Four Winds by clicking the "Click Here" button on the This is a secure message screen.
- Click "Save" or "yes" when asked if you want to save the password.
- In subsequent emails you should not need to enter a password.
- Just select "Click Here" and you will be brought to a screen to enter your email address and a password of your choosing.

Sometimes your email server may initially flag a Four Winds Proofpoint email as "Junk". To avoid this, you should add us to your trusted email list. Also, please note that only the body of the email is encrypted, not the subject line. Therefore our email will not include patients' names in the subject line. Please do not include patients' names in the subject line when sending email to us or replying to our email.

Thank you for your attention to this matter. Again, use of this email system is optional and choosing not to use it has no effect on other aspects of your treatment. During program hours, you can also reach a member of our staff by calling 518-584-3600 x3290.

Sincerely,

Erin Babitts, LCSW
Program Director
Four Winds Hospital Behavioral Health Services

PATIENT'S BILL OF RIGHTS

Four Winds Hospitals Notices

Westchester
800 Cross River Road
Katonah, NY 10536
914-763-8151

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
518-584-3600

A MESSAGE TO OUR PATIENTS AND FAMILIES

Four Winds Hospitals is required by confidentiality laws to protect against access to patient clinical information by unauthorized third parties and to assure that such information is not altered. At the current time, Four Winds will not make or accept e-mail communication about patients.

NOTICE OF PHYSICIAN OWNERSHIP AND PHYSICIAN COVERAGE

Four Winds Hospital believes that you are entitled to make informed decisions regarding your medical care. Medical staff, including nurses, clinicians and physicians, are either present at the Hospital or available "on-call" by telephone at all times. However, a physician is not on-site 24 hours per day, 7 days per week. If a medical emergency arises when a physician is not on-site, the hospital will initiate its Rapid Response protocol and provide treatment to the patient, and if needed CPR and emergency transport to a local medical facility by an ambulance service dispatched by phoning 911. The physician "on-call" will be notified. The Hospital hereby notifies you that it meets federal definition of a physician-owned hospital, pursuant to 42 C.F.R. section 4893. The list of the Hospital's physician owners or investors is available to you upon request from Beth Palmateer, the Hospital's Director of Quality Management who may be reached at 1-518-584-3600, ext. 3404

BILL OF RIGHTS & RESPONSIBILITIES

1. The right to considerate, respectful care at all times under all circumstances with recognition of personal dignity.

2. The right to impartial access to treatment or accommodations that are available or medically indicated, regardless of age, race, ethnicity, religion, culture, gender, gender identity or expression, sexual orientation, physical or mental disability, language, socioeconomic status or sources of payment for care.

3. The right of the patient to hospital's response to his/her requests and needs for treatment and service within the hospital's capacity, stated mission, and applicable law and regulation.

4. The right to express spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment for the patient.

5. The right, within the law, to personal and informational privacy, as manifested by:
   a. the right to refuse to talk with or see anyone not officially connected with the hospital, including visitors or persons officially connected with the hospital but not directly involved in his/her care.
   b. the right to wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment.
   c. the right to expect that any discussion or consultation involving his/her case will be conducted discreetly and that individuals not directly involved in his/her care will not be present without his/her permission.
   d. the right to have his/her medical record read only by individuals directly involved in his/her treatment or in the monitoring of its quality, or otherwise associated with Four Winds Hospital and by other individuals only on his/her written authorization or that of his/her legally authorized representative. Information from the medical records may be used as part of research studies conducted by Four Winds Hospital or individuals associated with Four Winds Hospital. This information will be presented as part of group data only and will not include any information that would identify an individual patient.

e. the right to expect all communications and other records pertaining to his care, including the source of payment for treatment, to be treated as confidential.
f. the right to request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing him/her and if another room equally suitable for his/her care and needs is available.
g. the right to be interviewed and examined in surroundings designed to assure reasonable, visual and auditory privacy. This includes the right to have a person of one's own sex present during certain parts of a physical examination, treatment or procedure performed by a health professional of the opposite sex and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
h. the right to be placed in protective privacy when considered necessary for personal safety.

6. The right to expect reasonable safety and a sanitary environment insofar as the hospital practices are concerned.

7. The right to know the identity and professional status of individuals providing service to him/her and to know which physician or other practitioner is primarily responsible for his/her care. This includes the patient's right to know of the existence of any professional relationship among individuals who are treating him/her, as well as the relationship of any other health care or educational institutions involved in the care.

8. The right to obtain from the practitioner responsible for coordinating his/her care, complete and current information concerning his/her diagnosis (to the degree known), treatment and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

9. The right to know the reasons for any proposed change in professional staff responsible for the patient.

10. Consent:
    a. the right to reasonable informed participation in decisions involving his/her health care. To the degree possible, this should be based on a clear, concise explanation of his/her condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient should not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. When the parents or legal guardians of a minor patient disagree on accepting treatment recommendations, the responsible clinicians shall work with the family to reach consensus. If consensus cannot be reached, and appropriately alternative treatments are not acceptable either, staff will seek transfer of the patient to an appropriate facility of the family/guardian's choice.
    b. the right to know who is responsible for authorizing and performing the procedures or treatment.
    c. the right to be informed if the hospital proposes to engage in or perform human experimentation or other research/educational projects affecting his/her care or treatment; the patient has the right to refuse to participate in any such activity.

11. The right to consult with a specialist.

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12. The right to receive interpretive services at no additional charge when hearing, sight or other impairment and/or limited English proficiency prevents equal opportunity to benefit from services and impedes an effective exchange of information between staff, the patient, and the patient's family. Interpretive services will be provided by interpreters qualified to provide the service. To protect confidentiality of the information and ensure accurate communication, family members or friends of the patient cannot be used as translators unless specifically requested by the patient.

13. The right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal. When refusal of treatment by the patient or his/her legally authorized representative prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice. When the patient is not legally responsible, the Hospital respects the surrogate decision maker's right, as allowed by law, to refuse care, treatment, and services on the patient's behalf.

14. The right to complete explanation of the need for a transfer and of the alternatives to such a transfer. The transfer must be acceptable to the other facility or organization. The patient has the right to be informed by the practitioner responsible for his care, or his delegate, of any continuing health care requirements following discharge from the hospital (see Policy "Transfer of Patients").

15. The right to formulate advance directives and appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law. The provision of care is not conditioned on the existence of an advance directive.

16. The right to request and receive an itemized and detailed explanation of his/her total bill for services rendered in the hospital regardless of the source of payment for his care. The patient has the right to a timely notice prior to termination of his/her eligibility for reimbursement by any third party payer for the cost of his care.

17. The right to be informed of the hospital rules and regulations applicable to his/her conduct as a patient.

18. The right to involve a significant individual such as a relative or close friend to actively participate in the development of your treatment plan and discharge plan.

19. Minor patients age 16 or older have the right to object to the involvement of his/her parent(s) in treatment if it is determined by a physician that the involvement of parent(s) would not be clinically appropriate.

20. The right to a balanced and nutritional diet.

21. The right to practice religion.

22. The right to freedom from abuse and mistreatment by employees or other patients of the hospital.

23. The right to adequate grooming and personal hygiene supplies.

24. The right to a reasonable amount of safe storage space for clothing and other personal property.

25. The right to a reasonable degree of privacy in sleeping, bathing and toilet areas.

26. The right to appropriate medical and dental care.

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27. The right to be free from physical pain.

28. The right to be informed about the unanticipated outcomes of care, treatment, and services when not otherwise already aware of the event or when further discussion is needed. Guardians have the right to receive telephone notification of an incident involving the patient, and upon request, to receive a copy of the incident report, and to have a meeting held with the Director of Quality Management to further discuss the incident.

29. The right to bring to the hospital any questions or complaints about the quality of care without negative consequences to the patient. The Director Quality Management, Donna Fenty, RN, MS, ext. 2597 is available to receive complaints from patients and families and to discuss them. A timely response shall substantially address the complaint. The complaint is analyzed and when indicated appropriate corrective action is taken. The Special Review Committee can be utilized to resolve issues as well. Presentation of a complaint will not serve to compromise a patient's future access to care. When resolution of a complaint is not satisfactory for a patient, the patient may request review of the complaint by the Regional Office of the NY State Office of Mental Health, The Mental Hygiene Legal Service, The Commission on Quality of Care for the Mentally Disabled or The Joint Commission.

30. The right to receive individualized treatment, including at least the following:
    a. the provision of an individual treatment plan.
    b. the periodic review of the patient's treatment plan.
    c. the active participation of patients over twelve years of age and their parents, relatives, or guardians in planning for treatment.
    d. the provision of an adequate number of competent, qualified and experienced professional clinical staff to supervise and implement the treatment plan.
    e. the provision of support services for individuals with vision, speech, hearing or cognitive deficits.

31. The right of the patient and/or the guardian to participate in the consideration of ethical issues that arise in their care.

32. The right for each patient's family and significant other, regardless of their age, to visit the patient, unless such visits are clinically contraindicated.

33. The right to suitable areas for patients to visit in private, unless such privacy is contraindicated by the patient's treatment plan.

34. The right for patients to send and receive mail without hindrance, unless clinically contraindicated.

35. The right to conduct private telephone conversations with family and friends, unless clinically contraindicated.

36. The right to have restrictions on visitors, telephone calls or other communications evaluated for therapeutic effectiveness by the clinically responsible staff.

37. If limitations on visitors, telephone calls or other communications are indicated, such limitations are determined with the participation of the patient and the patient's family.

38. The right to be informed of his/her rights in a language the patient understands.

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38. In the event that the hospital provides care of the dying patient, the hospital shall optimize the comfort and dignity of the patient through treating primary and secondary symptoms that respond to treatment as desired by the patient or surrogate decision maker, effective management of pain and acknowledging the psychosocial and spiritual concerns of the patient and the family regarding the dying and the expression of grief by the patient and family.

39. The right of the patient's guardian, next of kin, or legally authorized responsible person to exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient has been adjudicated incompetent in accordance with law, is found by his/her physician to be medically incapable of understanding the proposed treatment or procedure, is unable to communicate his/her wishes regarding treatment or is a minor.

PATIENT RESPONSIBILITIES

1 A patient has the responsibility to provide to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his health. He/she has the responsibility to report unexpected changes in his/her condition to the responsible practitioner. A patient is responsible for reporting whether he/she clearly comprehends a contemplated course of action and what is expected of him/her.

2. A patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for his/her care. This may include following the instructions of nurses and other health personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders, and as they enforce the applicable hospital rules and regulations. The patient is responsible for keeping appointments and, when he is unable to do so for any reason, for notifying the responsible practitioner.

3. The patient is responsible for his/her actions if he/she refused treatment or does not follow the practitioner's instructions.

4. The patient is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.

5. The patient is responsible for following hospital rules and regulations affecting patient care and conduct.

6. The patient is responsible for being considerate of the rights of other patients and hospital personnel and for assisting in the control of noise, smoking, and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the hospital.

5/04, 10/07, 10/09, 2/11, 12/11, 2/12, 01/13, 03/2023

s://manuals/current manuals/patient care/2007PC5.doc/V-18

Four Winds Hospitals

Westchester
800 Cross River Road
Katonah, NY 10536
Phone: (914) 763-8151 1-800-528-6624

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
Phone: (518) 584-3600 1-800-888-5448

www.fourwindshospital.com

If you have any questions about this Notice please contact the Hospital's Privacy & Compliance Officer, Michelle Blanchard, 518-584-3600 ext. 3312.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

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.

For certain types of disclosures of information in your medical record at a psychiatric hospital, New York State law may be more stringent than the federal law. For example the New York Mental Hygiene Law generally does not permit the disclosure of a clinical record except under circumstances specifically set forth in the law. The Hospital will follow New York law when it is more restrictive.

Get an electronic or paper copy of your medical record	You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 10 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

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 operations. • We are not required to agree to your request, and we may say "no" if it would affect your care. • 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 operations with your health insurer. • We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide this accounting for free.
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.
Choose someone to act for you	• If you have given someone 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.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting Monica Broderick, 914-763-8151 Ext. 2349• 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 www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation *If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

To treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: The psychiatrist treating you may ask your outpatient psychiatrist about your treatment.*
Run our organization	• We can use and share your health information to run our hospital, 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.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – 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. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research. All research projects for patients receiving psychiatric services are subject to a special approval process under New York law.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services or the NYS Office of Mental Health if it wants to see that we're complying with federal and/or state privacy law. • We can share health information about you in response to a court or administrative order, or in response to a subpoena. • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services.
Inmates	If you are an inmate of a correctional facility, we may disclose medical information necessary for making a determination regarding your health care, security, safety or ability to participate in programs when the chief administrative officer of the facility has made a request for it.

Work with a medical examiner	• We can share health information with a coroner or medical examiner when an individual dies.
Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.
Other	We do not create or manage a hospital directory. We do not contact patients for marketing or fundraising efforts.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will 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 here 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.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

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 of this Notice: 03/20/2023

This Notice of Privacy Practices applies to Four Winds Hospitals

JOHNATHAN'S LAW
INFORMATION SHEET

Johnathan's Law is a New York State law that makes certain records about adverse incidents more accessible. Records are accessible to Four Winds Hospitals patients and other individuals who are "qualified persons"

A **qualified person** is defined as:'

- anyone receiving services (the patient) or
- the patient's legal guardian or
- Parents, spouses or adult children who have the legal authority to provide consent for care and treatment

The term **incident** means "an accident or injury that affects the health or safety of a patient".

What must Four Winds Hospitals provide to qualified persons under Johnathan's Law?

- You are entitled to request documentation related to an incident in which you have been involved.
- You are entitled to requests documents related to an incident involving a patient if you are identified as the qualified person for that patient.
- Your treatment team will discuss the incident with you upon request.

ADVANCE DIRECTIVE

PLANNING FOR YOUR MENTAL AND PHYSICAL HEALTH CARE AND TREATMENT

Westchester
800 Cross River Road
Katonah, New York 10536
914-763-8151

Saratoga
30 Crescent Avenue
Saratoga Springs, New York 12866
518-584-3600

www.fourwindshospital.com

An Advance Directive is a type of written or verbal instruction about health care to be followed if a person becomes unable to make decisions regarding his or her medical treatment. Because you prepare an Advance Directive when you are competent, it will be followed during periods of time when you lack capacity to make medical treatment decisions. There are several different types of Advance Directives, including a ***health care proxy***, a ***living will***, and a ***do not resuscitate (DNR) order***. Each one of these is described in this pamphlet.

Why should I create an Advance Directive?
Sometimes, because of illness or injury, people are not able to decide about treatment for themselves. You may want to plan in advance and create an Advance Directive to appoint a health care agent and/or make your wishes and instructions known regarding your mental and physical health care, so that these wishes may be followed if you become unable to decide for yourself for a short or long term period. If you don't plan ahead, family members or other people close to you may not be allowed to make decisions for you or follow your wishes, and/or no one will know what treatment choices you may have preferred.

How do I create an Advance Directive?
You can use the form and directions in this pamphlet or have an attorney create an alternative form for you. The New York State Department of Health can provide you with forms and information regarding Advance Directives as well.

Can anyone refuse to provide me with mental or physical health treatment because I have created an Advance Directive?
No. It is against the law for treatment providers to discriminate against someone because he or she has an Advance Directive.

On what basis will a physician determine that I am incapable of making mental and physical health care decisions?
Your capacity to consent to mental and physical health care is determined by your ability to understand the nature and consequences of health care decisions, including the benefits, risks, and alternatives to proposed treatment, and then to make an informed choice.

Can I make decisions in advance using an Advance Directive about whether or not I want involuntary psychiatric hospitalization?
No. New York State Mental Hygiene Law Article 9 governs the admission of patients to a hospital for involuntary psychiatric care. You therefore cannot make decisions regarding whether or not to undergo involuntary psychiatric hospitalization in an Advance Directive.

If I object to any mental health treatment when my Advance Directive is in effect, will my objection be honored?
Your present objection to treatment will override the instructions contained in your Advance Directive and/ or the decisions made by your health care agent. You will have the same rights regarding your present objection to treatment that you would have had if you made no Advance Directive.

GENERAL QUESTIONS ABOUT ADVANCE DIRECTIVES

If I wish to use the attached form as my Advance Directive, must I complete the entire form?
If you choose to use the attached form, you should make sure that your name is stated at the beginning of each form and that the section regarding signatures and witnesses is completed as necessary. However, you can choose whichever other sections within the form regarding your treatment decisions that you wish to complete. ***It is your choice whether to fill out this form and what provisions to include in it.***

May anyone help me to fill out the Advance Directive form in this pamphlet?
You may ask anyone you wish to help you fill out the Advance Directive form. You may want to discuss its provisions with your mental or physical health care treatment providers. A mental health peer advocate who has been trained to assist in preparing Advance Directives may also be helpful. However, you must make the final decisions and sign the Advance Directive. You cannot be forced to fill out an Advance Directive by anyone, including a family member or treatment provider.

To whom should I give copies of my Advance Directive?
You should give copies of your Advance Directive to your health care agent and alternate agent (if you have appointed them), to the treatment providers and health care professionals who routinely provide care to you, and to your family or friends. You may also want to give a copy to the hospital where you are likely to be treated if the need arises, and to keep a copy with your important papers.

HEALTH CARE PROXIES

What is a Health Care Proxy?
A New York Law called the Health Care Proxy Law allows you to appoint someone you trust and who knows you well, such as a family member or close friend, who will agree to act in your best interests regarding your health care if you lose the ability to make decisions about treatment for yourself. The document in which you appoint this person as your health care agent is called a Health Care Proxy.

What is the purpose of a Health Care Proxy?
The Health Care Proxy Law gives you the power to ensure that health care professionals know your wishes regarding medical treatment. Your health care agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors, and other health care providers must follow your agent's decisions as if they were your own.

If I appoint a health care agent, how much authority does he or she have to make treatment decisions on my behalf?
You can give your agent as little or as much authority as you want. You can allow your agent to decide about all health care or only certain treatments. For example, you may appoint a health care agent to make decisions only about your mental health care. However, you may not appoint more than one health care agent to act at a given time (e.g., you cannot appoint one for physical health care decisions and one for mental health care decisions). If your health care agent is not aware of your wishes about artificial nutrition and hydration (nourishment and water provided by feeding tubes), he or she will not be able to make decisions about these measures. You may also give your agent instructions that he or she has to follow. Your agent must follow your verbal and written instructions, as well as your moral and religious beliefs. You may include a living will and/or a statement of your preferences and desires regarding medical treatment with your health care proxy, which can provide a useful resource for your health care agent. If your agent does not know your wishes and beliefs, your agent is legally required to act in your best interests.

How does appointing a health care agent empower me?
Appointing an agent lets you control your medical treatment by:

- allowing your agent to stop treatment when he or she decides that is what you would want or what is best for you under the circumstances; and
- choosing one person to decide about treatment because you think that person would make the best decisions or because you want to avoid conflict or confusion about who should decide.

What are the advantages of creating a Health Care Proxy?
The purpose of the Health Care Proxy law is to give a person of your choice the authority to speak for you when you are incapacitated to ensure that decisions regarding your medical treatment are made in accordance with your wishes, including your religious and moral beliefs if known to your agent, or, if your agent does not know your views, in accordance with your best interests. Therefore, a major advantage in appointing a health care agent through a Health Care Proxy is that you do not have to know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made. The Health Care Proxy is just as useful for decisions to receive treatment as it is for decisions to stop treatment.

What are the disadvantages of creating a Health Care Proxy?
It is very important that the person you choose to be your health care agent be an adult that you trust to protect your wishes and interests. If there is no such adult in your life, you may wish to consider a Living Will to provide guidance about your attitudes and preferences regarding your medical care.

Who should I choose to be my health care agent?
The health care agent must be an adult 18 years of age or older. It is not necessary that he or she reside in New York State. You should choose a person you trust to protect your wishes and interests. An operator, administrator or employee of a general hospital, nursing home, mental hygiene facility, or hospice cannot serve as an agent for you if you are a patient at the facility, unless you are related to the person you wish to appoint, or you created the Health Care Proxy before being admitted to, or applying for admission to, the facility. You can appoint your physician as your agent, but the physician will not be able to serve both as your agent and your attending physician after his or her decision-making authority as your agent begins. Furthermore, if you appoint a physician as your agent, that physician cannot determine your capacity to make health care decisions.

How can I appoint a health care agent?
All competent adults can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer, just two adult witnesses. You can use the form in this pamphlet, but you don't have to.

When would my health care agent begin to make treatment decisions for me?
Your health care agent would begin to make treatment decisions after doctors decide that you are not able to make health care decisions. If you regain capacity to make health care decisions, the health care agent's decision making authority ends. ***As long as you are able to make treatment decisions for yourself, you will have the right to do so.***

Will my agent's decisions be honored?
All hospitals, doctors, and other health care facilities are legally required to honor the decisions by your agent, unless they obtain a court order overriding the decision.

What if my health care agent is not available when decisions must be made?
You can appoint an alternate agent to decide for you if your health care agent is not available or able to act when decisions must be made. Otherwise, health care providers will make treatment decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What are the requirements for signing and witnessing a Health Care Proxy?
You must sign and date a Health Care Proxy in order for it to be enforceable. You must include the name of your agent and state that you intend the agent to make health care decisions for you. You must sign the Health Care Proxy in the presence of two witnesses who are 18 years of age or older. Neither witness can also be the person who you are appointing as your health care agent. The witnesses must also sign the document and state their belief that you are personally known to them, you appear to be of sound mind, and you are acting of your own free will. If you create your Health Care Proxy while you are a resident in a facility operated or licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities, one of those witnesses **cannot** be affiliated with that facility. And, if the facility in which you reside is a hospital, at least one of those witnesses must be a "qualified" psychiatrist (i.e., he or she is board eligible or board certified) or Psychiatric Nurse Practitioner.

What if I change my mind?
You should review your Health Care Proxy periodically to ensure that the document you signed still represents your current wishes. It is easy to cancel the proxy, to change the person you have chosen as your health care agent, or to change any treatment instructions you have written on your Health Care Proxy form. All you need to do is fill out a new form, or simply state that the Health Care Proxy is revoked. You should notify your agent, your attorney, your physician or any other health care provider, your family and friends, and anyone who has a copy, verbally and in writing, of your change or revocation.

How long is a Health Care Proxy valid?
The Health Care Proxy will be valid unless and until you cancel it. In addition, you can require that the Health Care Proxy expire on a specified date or if certain events occur. If you choose your spouse as your health care agent and you get divorced or legally separated, the appointment is automatically canceled.

LIVING WILLS

What is a Living Will?
A Living Will is a written document in which you, as an adult who is now competent, can express your wishes regarding your future health care in the event that you are unable to make health care decisions. You can also include a statement of your preferences and desires regarding medical treatment with your Living Will, which can provide a useful resource for your treatment providers.

Is a Living Will valid in New York State?
Unlike the Health Care Proxy, there is no specific law in New York that establishes Living Wills. However, the courts in New York have honored Living Wills that have established a person's wishes by "clear and convincing proof." That is, it must be shown that the person who has become incapable had previously given clear and specific instructions regarding a certain type of medical care or procedure.

What is the difference between a Living Will and a Health Care Proxy?
A Living Will is a document in which you can give specific instructions about your health care treatment, as well as express your attitudes and wishes about your health care.

A Health Care Proxy is different because it allows you to choose someone you trust to make treatment decisions on your behalf in case you lose your decision-making capacity. With a Health Care Proxy, you don't need to know in advance what will happen to you or what your medical needs might be in the future.

How does creating a Living Will empower me?
A Living Will serves to make your wishes and instructions known regarding your mental and physical health care, if you become incapable of making treatment decisions. Treatment providers should follow your specific instructions. The instructions you write in this document would be evidence of your expressed wishes in the event that your wishes are challenged in court.

What are the advantages of a Living Will?
If you have no one you can appoint to be your health care agent, or you do not wish to appoint one, yet you still want to make your wishes about your health care preferences known, a Living Will is a legally valid way of recording these instructions. This information will provide evidence of your wishes should you become incapable of making treatment decisions.

What are the disadvantages of a Living Will?
General instructions about refusing treatment, even if written down, may not be effective if they do not meet the "clear and convincing proof" test. Further, expressions of intent regarding unforeseen circumstances or new developments in technology cannot be reflected in a Living Will unless it is routinely updated.

Can I create both a Health Care Proxy and a Living Will?
Yes. If you complete a Health Care Proxy form, but also have a Living Will, the Living Will provides instructions for your health care agent, and will guide his or her decisions. Copies of your Living Will should be given to your health care agent. You will want to have your health care agent share the views expressed in the Living Will with your health care providers to make sure your wishes are understood. With both documents, if you include a statement of your preferences regarding your medical treatment, it will provide additional useful guidance.

What are the requirements for signing and witnessing a Living Will?
Because there is not a specific law that governs Living Wills, there are no exact requirements with regard to signatures and witnesses. However, it is recommended that you follow the requirements for signing and witnessing a Health Care Proxy when executing a Living Will.

What if I change my mind?
You should review your Living Will from time to time to ensure that the document you signed still represents your current wishes. You can change or revoke your Living Will by making a new one, destroying it, or simply stating that it is revoked. You should be sure to tell your treatment providers and your family and/or friends that you have revoked your Living Will.

How long is a Living Will valid?
The Living Will should be valid unless and until you revoke it.

DO NOT RESUSCITATE (DNR) ORDERS

What is a Do-Not-Resuscitate (DNR) Order?
Cardiopulmonary resuscitation (CPR) refers to the medical procedures used to restart a person's heart and breathing when the person suffers heart failure. CPR may involve simple efforts such as mouth-to-mouth resuscitation and external chest compression. Advanced CPR may involve electric shock, insertion of a tube to open the patient's airway, injection of medication into the heart and, in extreme cases, open chest heart massage.
A do-not-resuscitate (DNR) order tells medical professionals not to perform CPR. This means that doctors, nurses, and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heartbeat stops. A DNR order is only a decision about CPR and does not relate to any other treatment.

Can I request a DNR Order?
Yes. All adult patients can request a DNR order.
If you have not requested a DNR order and have not appointed a health care agent to decide for you, a family member or close friend can consent to a DNR order when you are terminally ill, permanently unconscious, CPR will not work (would be medically futile) or CPR would impose an extraordinary burden on you given your medical condition and the expected outcome of CPR. Anyone deciding for you must base the decision on your wishes, including your religious and moral beliefs, or if your wishes are not known, on your best interests.

How can I make my wishes about DNR known?
During hospitalization, an adult patient may consent to a DNR order verbally or in writing, if two adult witnesses are present. When consent is given verbally, one of the witnesses must be a physician affiliated with the hospital. Prior to hospitalization, consent must be in writing in the presence of two adult witnesses. In addition, the Health Care Proxy law allows you to appoint someone you trust to make decisions about CPR and other treatments if you become unable to decide for yourself.

What if I lose the ability to make decisions about CPR and do not have anyone who can decide for me?
A DNR order can be written if two doctors decide that CPR would not work or if a court approves of the DNR order. It would be best if you discussed your wishes about CPR with your doctor in advance.

What if I change my mind?
You or anyone who consents to a DNR order for you can revoke consent for the order by telling your doctor, nurses, or others of the decision.

NOTE: THESE DIRECTIONS AND FORMS ARE NOT INTENDED TO CONSTITUTE LEGAL ADVICE. YOU MAY WISH TO CONSULT WITH YOUR OWN ATTORNEY FOR ADVICE SPECIFIC TO YOUR SITUATION.

I, _____, hereby make known my desire that, should I lose the capacity to make health care decisions, the following are my instructions regarding consent to or refusal of medical treatment, and if I choose, the designation of my health care agent. I intend that all completed sections of this advance directive be followed.

PART I. HEALTH CARE PROXY

A. **APPOINTMENT OF A HEALTH CARE AGENT:** I hereby appoint the following individual as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This health care proxy shall take effect when and if I become unable to make my own health care decisions.

_____
(Agent's Name)

_____
(Agent's Home Address)

_____
(Agent's Telephone Number)

B. **AUTHORITY OF HEALTH CARE AGENT:** My health care agent may make decisions regarding* (choose ONE):
- ☐ all mental and physical health care
- ☐ mental health care ONLY
- ☐ physical health care ONLY
- ☐ the following health care decisions ONLY _____

_____

_____

**Note: While you may limit your health care agent's decision-making authority, you cannot appoint more than one health care agent at a time. For example, you cannot appoint one health care agent to make only physical health care decisions and another one to make only mental health care decisions.*

C. **ALTERNATE HEALTH CARE AGENT** *(optional)*: If the person appointed above is unable or unwilling to serve as my health care agent, I hereby appoint the following individual to act as my alternate health care agent.

_____
(Agent's Name)

_____
(Agent's Home Address)

_____
(Agent's Telephone Number)

D. **DURATION OF PROXY:** Unless I revoke it, this health care proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specify date or conditions, if desired):

_____
_____
_____
_____
_____

PART II. STATEMENT OF DESIRES AND INSTRUCTIONS REGARDING MENTAL AND PHYSICAL HEALTH CARE AND TREATMENT

I direct my agent to make health care decisions in accordance with my wishes and limitations as stated in this Advance Directive, or as he or she otherwise knows. If I have not appointed a health care agent, I wish my health care providers to act in accordance with my instructions as stated below.
[Note: Unless your agent knows your wishes about artificial nutrition and hydration (tube feeding), your agent will not be allowed to make decisions about artificial nutrition and hydration.]

A. SPECIAL INSTRUCTIONS REGARDING MY MENTAL HEALTH CARE AND TREATMENT

1. **Medications for Psychiatric Treatment**: If it is determined that I am not legally capable of consenting to or refusing medications relating to my mental health treatment, my wishes are as follows:
   (a) I prefer to be given the following medications

Medication Name:

_____
_____
_____
_____
_____

(b) I prefer not to be given the following medications, for the following reasons:

Medication:_____
Reason: _____
Medication:_____
Reason: _____
Medication: _____
Reason: _____

2. **Treatment Facilities**: If my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care the following are my instructions.

(a) I would prefer to receive this care at the following hospitals or programs/facilities, if possible:

_____
_____
_____

(b) I prefer not to receive this care at the following hospitals or programs/facilities, if possible, for the reasons I have listed:

Facility: _____
Reason: _____
Facility: _____
Reason: _____

(c) My choice of treating physician, if possible, is:

_____Phone # _____

OR

_____ Phone # _____

OR

_____ Phone # _____

(d) I do not wish to be treated by the following physicians, if possible, for the reasons stated:

Dr.'s Name: _____

Reason: _____

Dr.'s Name: _____

Reason: _____

3. **Additional Instructions Regarding My Mental Health Care**: (e.g., individual psychotherapy, group therapy, electroconvulsive therapy, self-help services, research):

_____
_____
_____
_____
_____
_____

B. **Special Instructions Regarding My Physical Health Care and Treatment**

1. These wishes should be followed if: *(choose one of the following)*

☐ I am terminally ill, in a coma or unconscious, or in an irreversible condition from which there is no reasonable hope of recovery, **OR**

☐ the following medical conditions exist:

_____
_____
_____

2. Medical treatment about which you may wish to give your agent or health care providers special instructions include the following treatments. Write instructions for each treatment you choose on the lines provided.

☐ Artificial respiration: _____

☐ Artificial nutrition and hydration: _____

☐ Cardiopulmonary resuscitation: _____

☐ Antibiotics: _____

☐ Dialysis: _____

☐ Transplantation: _____

☐ Blood transfusions or blood products:_____

☐ Invasive diagnostic tests: _____

☐ Other physical health treatments or medications: _____
_____
_____
_____
_____
_____

Additional instructions regarding physical health care and treatment:
_____
_____
_____
_____
_____

PART III. IMPORTANT INFORMATION IF I AM HOSPITALIZED

(You may choose to complete this section to provide additional guidance to your health care agent and/or providers.)

I wish to provide the following information regarding my current mental health care and treatment and to state my preferences regarding mental health care and treatment, in the event I am hospitalized. I strongly hope that my stated preferences will be honored to assist me in having more control over my life and to aid in my recovery.

A. **MY PHYSICIAN AND/OR PSYCHIATRIST'S NAME AND ADDRESS:**
_____
_____
_____
_____

B. **MY OUTPATIENT MENTAL HEALTH CARE PROVIDER(S):**
_____
_____
_____
_____

C. **Approaches That Help Me when I'm Having A Hard Time:**

If I am having a hard time, the following approaches have been helpful to me in the past. I would like the staff to try to use these approaches with me:

___ Voluntary time out in my room
___ Voluntary timeout in quiet room
___ Sitting by staff
___ Talking with a peer
___ Having my hand held
___ Going for a walk
___ Punching a pillow
___ Writing in a journal
___ Lying down
___ Talking with staff
___ Listening to music
___ Reading
___ Watching TV
___ Pacing the halls
___ Calling a friend
___ Calling my therapist
___ Pounding some clay
___ Deep breathing exercises
___ Taking a shower
___ Exercising

Other:_____
_____

D. **Actions That Are Not Helpful:**
In the past, I have found that the following actions make me feel worse. I prefer that staff not do the following:

_____
_____
_____
_____

E. **Preferences Regarding Physical Contact by Staff:**

_____
_____
_____
_____

F. **Hospital and Community Treatment Programs:** (outpatient clinics, community based residential facilities, community support programs, self-help programs, etc.) Upon my discharge, if possible, I would like to receive treatment from the following hospitals and community treatment programs:

_____
_____
_____
_____

Upon my discharge, if possible, I do not want to receive treatment from the following hospitals or community treatment programs for the reasons listed:
Provider: _____
Reason: _____
Provider: _____
Reason: _____
Provider: _____
Reason: _____

G. **ADDITIONAL PREFERENCES REGARDING MY MENTAL HEALTH CARE AND TREATMENT:**

_____

_____

_____

PART IV. SIGNATURE AND STATEMENT OF WITNESSES

A. Your Signature: _____

Address: _____

Date: _____

B. Statement by Witnesses (must be age 18 or older) **Witness #2, may not be an employee of the facility.**

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1: _____
(Name – Psychiatrist or Psychiatric Nurse Practitioner)

Four Winds Hospital_____
(Address)

Witness 2: _____
(Name)

_____
(Address)

NOTE: If you are a resident at an OMH or OMRDD operated or licensed facility, special witnessing requirements apply. See instructions or ask staff to assist you.