

HILLSIDE MEDICAL GROUP

12881 I35 N, Live Oak, TX 78233 • 210-742-6555 • www.hillsidemedicalgroup.com

Medical Power of Attorney

DESIGNATION OF HEALTH CARE AGENT • TEXAS HEALTH & SAFETY CODE §166.164 • FORM 05/2024

WHAT THIS FORM DOES

This form names the person (your "agent") you want to make medical decisions for you if you ever become unable to make them yourself. This is the single most useful advance directive to have on file.

HOW TO FILL IT OUT

1. Write the name, address, and phone number of the person you choose as your agent.
2. If you wish, name one or two alternate agents in case your first choice cannot serve.
3. List any limits on your agent's authority (optional).
4. Read the Disclosure Statement, then sign.

Your agent's authority begins only when your doctor certifies in writing that you cannot make your own decisions. Your agent may NOT consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion.

HOW TO MAKE IT VALID

Sign the form in ONE of these two ways:

- In front of a notary public, OR
- In front of two competent adult witnesses.

A witness may not be: your agent, a relative by blood or marriage, someone entitled to part of your estate, your attending physician or their employee, a person with a claim against your estate, or (if a facility employee) someone providing you direct patient care or a facility officer/manager.

This document cannot be changed. To make changes, complete a new Medical Power of Attorney.

Need help filling this out? Hillside can set up a nursing visit to walk you through this form step by step. Ask our front desk or call 210-742-6555 to schedule.

WHEN YOU ARE FINISHED

- Give a copy to your Hillside care team so it can be added to your medical record.
- Keep the original for yourself. Give copies to your agent, your family, and any hospital you use.
- You can update or cancel this form at any time by completing a new one.

Medical Power of Attorney Designation of Health Care Agent (MPOA)

Advance Directives Act (see §166.164, Health and Safety Code)

I, _____ (insert your name) appoint:

Name: _____

Address: _____

Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

Limitations On The Decision-Making Authority Of My Agent Are As Follows:

Designation Of An Alternate Agent:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____

Phone: _____

Second Alternate Agent

Name: _____

Address: _____

Phone: _____

The original of the document is kept at _____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

Duration

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(If Applicable) This power of attorney ends on the following date: _____

Prior Designations Revoked

I revoke any prior medical power of attorney.

Disclosure Statement

This Medical Power Of Attorney Is An Important Legal Document. Before Signing This Document, You Should Know These Important Facts:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life- sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

This Power Of Attorney Is Not Valid Unless:

- (1) You Sign It And Have Your Signature Acknowledged Before A Notary Public; Or
- (2) You Sign It In The Presence Of Two Competent Adult Witnesses.

The Following Persons May Not Act As One Of The Witnesses:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

(You Must Date And Sign This Power Of Attorney. You May Sign It And Have Your Signature Acknowledged Before A Notary Public Or You May Sign It In The Presence Of Two Competent Adult Witnesses.)

Signature Acknowledged Before Notary

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

(City and State)

(Signature)

(Print Name)

State of Texas

County of _____

This instrument was acknowledged before me on _____ (date) by _____
(name of person acknowledging).

Notary Public, State of Texas

Notary's printed name:

SEAL

My commission expires:

OR

Signature In Presence Of Two Competent Adult Witnesses

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

(City and State)

(Signature)

(Print Name)

Statement Of First Witness

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____
Printed Name: _____ Date: _____
Address: _____

Statement Of Second Witness

Signature: _____
Printed Name: _____ Date: _____
Address: _____

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Directive to Physicians and Family or Surrogates

LIVING WILL • TEXAS HEALTH & SAFETY CODE §166.033 • FORM 05/2024

WHAT THIS FORM DOES

This form lets you say what medical treatment you do or do not want if you become terminally or irreversibly ill and can no longer speak for yourself.

HOW TO FILL IT OUT

1. Write your name at the top of the directive.
2. Read each situation and put your initials next to the choice that matches your wishes.
3. Add any specific requests in the space provided (for example, feeding tubes or IV antibiotics).
4. If you do NOT have a Medical Power of Attorney, you may name up to two people to speak for you.
5. Sign and date the form.

HOW TO MAKE IT VALID

Sign the form in ONE of these two ways:

- In front of two adult witnesses, OR
- In front of a notary public.

Witness 1 may not be: the person you name to make decisions, a relative by blood or marriage, someone who inherits from you, your doctor or your doctor's employee, or (if a facility employee) a person giving you direct care.

Note: Under Texas law this directive has no effect while you are pregnant. It stays in effect until you revoke it.

Need help filling this out? Hillside can set up a nursing visit to walk you through this form step by step. Ask our front desk or call 210-742-6555 to schedule.

WHEN YOU ARE FINISHED

- Give a copy to your Hillside care team so it can be added to your medical record.
- Keep the original for yourself. Give copies to your agent, your family, and any hospital you use.
- You can update or cancel this form at any time by completing a new one.

Directive to Physicians and Family or Surrogates (Living Will)

Advance Directives Act (see §166.033, Health and Safety Code)

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

Directive

I, _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

- ☐ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
- ☐ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (This Selection Does Not Apply To Hospice Care.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

- ☐ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR
- ☐ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (This Selection Does Not Apply To Hospice Care.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do **not** have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make health care or treatment decisions with my physician compatible with my personal values:

- 1. _____
- 2. _____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed _____ Date _____
City, County, State of Residence _____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as **Witness 1** may not be a person designated to make a health care or treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____ Witness 2 _____

The declarant, in lieu of signing in the presence of witnesses, may sign the directive and have the signature acknowledged before a notary public.

Signature Acknowledged Before Notary

I sign my name to this Advance Directive to Physicians and Family or Surrogates on _____ day of _____
(month, year) at

(City and State)

(Signature)

(Print Name)

State of Texas

County of _____

This instrument was acknowledged before me on _____ (date) by _____
(name of person acknowledging).

Notary Public, State of Texas

Notary's printed name:

SEAL

My commission expires:

Definitions:

"Artificially administered nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the gastrointestinal tract.

"Irreversible condition" means a condition, injury, or illness:

- (1) that may be treated, but is never cured or eliminated;
- (2) that leaves a person unable to care for or make decisions for the person's own self; and
- (3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die.

You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

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Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order

TEXAS DSHS • HEALTH & SAFETY CODE CH. 166 • FORM 10/2023

Important: This order requires your physician's signature and must be completed on the official DSHS form for EMS to honor it. Please complete it with your Hillside provider. Ask the front desk or call 210-742-6555 to set up a visit.

WHAT THIS FORM DOES

This order tells emergency medical services (EMS) and other out-of-hospital staff NOT to attempt resuscitation — CPR, cardiac pacing, defibrillation, advanced airway management, or artificial ventilation — and to allow a natural death. Comfort care is still provided. It does not affect other emergency or comfort care.

HOW IT IS COMPLETED

1. The correct declaration section is completed depending on who is signing (see below).
2. Two competent adult witnesses sign, OR the signature is acknowledged before a notary.
3. The attending physician signs the Physician's Statement and notes the order in your medical record.

Who signs which section:

- Section A — a competent adult (18+) signing for themselves.
- Section B — legal guardian, medical power of attorney agent, or directive proxy.
- Section C — a qualified relative (spouse, adult child, parent, or nearest living relative).
- Section D — the attending physician, based on a prior directive or a non-written request.
- Section E — parent, legal guardian, or managing conservator of a minor.
- Section F — two physicians when there is no guardian, agent, proxy, or available relative.

REVOKING THE ORDER

You may revoke this order at any time by telling responding staff, destroying the order, or removing all OOH-DNR identification devices. It is automatically revoked if the person is known to be pregnant or in unnatural or suspicious circumstances.

Need help filling this out? Hillside can set up a nursing visit to walk you through this form step by step. Ask our front desk or call 210-742-6555 to schedule.

WHEN YOU ARE FINISHED

- Give a copy to your Hillside care team so it can be added to your medical record.
- Keep the original for yourself. Give copies to your agent, your family, and any hospital you use.
- You can update or cancel this form at any time by completing a new one.



OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name

Date of birth

☐ Male
☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Person's signature

Date

Printed name

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature

Date

Printed name

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature

Date

Printed name

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's

signature

Date

Printed
nameLic
#

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature

Date

Printed name

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature

Date

Printed name

Witness 2 signature

Date

Printed name

Notary in the State of Texas and County of

. The above noted person personally appeared before me and signed the above noted declaration on this date .

Signature & seal:

Notary's printed name

Notary Seal

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Physician's signature

Date

Printed name

License #

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's
signature

Date

Printed
name

Lic#

Signature of second physician

Date

Printed
name

Lic#

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature

Guardian/Agent/Proxy/Relative signature

Attending physician's
signature

Second physician's signature

Witness 1
signatureWitness 2
signatureNotary's
signature

This document or a copy thereof must accompany the person during his/her medical transport.

INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.

APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.

IMPLEMENTATION: A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:

Section A - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.

Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B.

Section C - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.

Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.

Section E - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.

Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is a representative of the ethics or medical committee of the health care facility in which the person is a patient.

In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

REVOCATION: An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.

AUTOMATIC REVOCATION: An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS

Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state. [HSC §166.002(12)].

Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]

Qualified Relative: A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.

Qualified Witnesses: Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.

Report problems with this form to the Texas Department of State Health Services (DSHS) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC §166.011

HILLSIDE MEDICAL GROUP

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Statutory Durable Power of Attorney

PROPERTY & FINANCES — NOT MEDICAL • TEXAS ESTATES CODE §752.051 • FORM 09/2017

Please note: This form is for your property and money only. It does NOT let anyone make medical decisions for you — that is the Medical Power of Attorney. It is included because patients often ask about it in the same conversation.

WHAT THIS FORM DOES

This form names an agent to handle your property and financial matters (such as banking, real estate, bills, and benefits) if you choose. The powers can be broad, so choose your agent carefully.

HOW TO FILL IT OUT

1. Write your name and address, and the name and address of the agent you appoint.
2. Put your initials next to each power you want to grant — or initial (O) to grant all of them.
3. Complete any special instructions (compensation, co-agents, gifts).
4. Choose when it takes effect, then sign before a notary.

HOW TO MAKE IT VALID

- Your signature must be acknowledged before a notary public.
- The powers are broad and sweeping — if you have questions, obtain competent legal advice.
- To sign home equity loan documents, this must be signed at the office of the lender, an attorney, or a title company.

Need help filling this out? Hillside can set up a nursing visit to walk you through this form step by step. Ask our front desk or call 210-742-6555 to schedule.

WHEN YOU ARE FINISHED

- Give a copy to your Hillside care team so it can be added to your medical record.
- Keep the original for yourself. Give copies to your agent, your family, and any hospital you use.
- You can update or cancel this form at any time by completing a new one.

STATUTORY DURABLE POWER OF ATTORNEY

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE DURABLE POWER OF ATTORNEY ACT, SUBTITLE P, TITLE 2, ESTATES CODE. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO. IF YOU WANT YOUR AGENT TO HAVE THE AUTHORITY TO SIGN HOME EQUITY LOAN DOCUMENTS ON YOUR BEHALF, THIS POWER OF ATTORNEY MUST BE SIGNED BY YOU AT THE OFFICE OF THE LENDER, AN ATTORNEY AT LAW, OR A TITLE COMPANY.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until:

- (1) you die or revoke the power of attorney;
- (2) your agent resigns, is removed by court order, or is unable to act for you; or
- (3) a guardian is appointed for your estate.

I, _____ (insert your name and address), appoint
_____ (insert the name and address of the person appointed) as my agent to act for me in any lawful way with respect to all of the following powers that I have initialed below. (YOU MAY APPOINT CO-AGENTS. UNLESS YOU PROVIDE OTHERWISE, CO-AGENTS MAY ACT INDEPENDENTLY.)

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (O) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS LISTED IN (A) THROUGH (N).

TO GRANT A POWER, YOU MUST INITIAL THE LINE IN FRONT OF THE POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF THE POWER. YOU MAY, BUT DO NOT NEED TO, CROSS OUT EACH POWER WITHHELD.

- _____ (A) Real property transactions;
- _____ (B) Tangible personal property transactions;
- _____ (C) Stock and bond transactions;
- _____ (D) Commodity and option transactions;
- _____ (E) Banking and other financial institution transactions;
- _____ (F) Business operating transactions;
- _____ (G) Insurance and annuity transactions;
- _____ (H) Estate, trust, and other beneficiary transactions;
- _____ (I) Claims and litigation;
- _____ (J) Personal and family maintenance;

- _____ (K) Benefits from social security, Medicare, Medicaid, or other governmental programs or civil or military service;
- _____ (L) Retirement plan transactions;
- _____ (M) Tax matters;
- _____ (N) Digital assets and the content of an electronic communication;
- _____ (O) ALL OF THE POWERS LISTED IN (A) THROUGH (N). YOU DO NOT HAVE TO INITIAL THE LINE IN FRONT OF ANY OTHER POWER IF YOU INITIAL LINE (O).

SPECIAL INSTRUCTIONS:

Special instructions applicable to agent compensation (initial in front of one of the following sentences to have it apply; if no selection is made, each agent will be entitled to compensation that is reasonable under the circumstances):

_____ My agent is entitled to reimbursement of reasonable expenses incurred on my behalf and to compensation that is reasonable under the circumstances.

_____ My agent is entitled to reimbursement of reasonable expenses incurred on my behalf but shall receive no compensation for serving as my agent.

Special instructions applicable to co-agents (if you have appointed co-agents to act, initial in front of one of the following sentences to have it apply; if no selection is made, each agent will be entitled to act independently):

_____ Each of my co-agents may act independently for me.

_____ My co-agents may act for me only if the co-agents act jointly.

_____ My co-agents may act for me only if a majority of the co-agents act jointly.

Special instructions applicable to gifts (initial in front of the following sentence to have it apply):

_____ I grant my agent the power to apply my property to make gifts outright to or for the benefit of a person, including by the exercise of a presently exercisable general power of appointment held by me, except that the amount of a gift to an individual may not exceed the amount of annual exclusions allowed from the federal gift tax for the calendar year of the gift.

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

UNLESS YOU DIRECT OTHERWISE BELOW, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT TERMINATES.

CHOOSE ONE OF THE FOLLOWING ALTERNATIVES BY CROSSING OUT THE ALTERNATIVE NOT CHOSEN:

(A) This power of attorney is not affected by my subsequent disability or incapacity.

(B) This power of attorney becomes effective upon my disability or incapacity.

YOU SHOULD CHOOSE ALTERNATIVE (A) IF THIS POWER OF ATTORNEY IS TO BECOME EFFECTIVE ON THE DATE IT IS EXECUTED.

IF NEITHER (A) NOR (B) IS CROSSED OUT, IT WILL BE ASSUMED THAT YOU CHOSE ALTERNATIVE (A).

If Alternative (B) is chosen and a definition of my disability or incapacity is not contained in this power of attorney, I shall be considered disabled or incapacitated for purposes of this power of attorney if a physician certifies in writing at a date later than the date this power of attorney is executed that, based on the physician's medical examination of me, I am mentally incapable of managing my financial affairs. I authorize the physician who examines me for this purpose to disclose my physical or mental condition to another person for purposes of this power of attorney. A third party who accepts this power of attorney is fully protected from any action taken under this power of attorney that is based on the determination made by a physician of my disability or incapacity.

I agree that any third party who receives a copy of this document may act under it. Termination of this durable power of attorney is not effective as to a third party until the third party has actual knowledge of the termination. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney. The meaning and effect of this durable power of attorney is determined by Texas law.

If any agent named by me dies, becomes incapacitated, resigns, or refuses to act, or is removed by court order, or if my marriage to an agent named by me is dissolved by a court decree of divorce or annulment or is declared void by a court (unless I provided in this document that the dissolution or declaration does not terminate the agent's authority to act under this power of attorney), I name the following (each to act alone and successively, in the order named) as successor(s) to that agent:

_____.

Signed this _____ day of _____, _____.

(your signature)

State of _____
County of _____

This document was acknowledged before me on _____ (date) by

(name of principal)

(Seal, if any, of notary)

(signature of notarial officer)

(printed name)

My commission expires: _____

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, you establish a “fiduciary” relationship with the principal. This is a special legal relationship that imposes on you legal duties that continue until you resign or the power of attorney is terminated, suspended or revoked by the principal or by operation of law. A fiduciary duty generally includes the duty to:

- (1) act in good faith;
- (2) do nothing beyond the authority granted in this power of attorney;
- (3) act loyally for the principal's benefit;
- (4) avoid conflicts that would impair your ability to act in the principal's best interest; and
- (5) disclose your identity as an agent when you act for the principal by writing or printing the name of the principal and signing your own name as “agent” in the following manner:

(Principal's Name) by (Your Signature) as Agent

In addition, the Durable Power of Attorney Act (Subtitle P, Title 2, Estates Code) requires you to:

- (1) maintain records for each action taken or decision made on behalf of the principal;
- (2) maintain all records until delivered to the principal, released by the principal, or discharged by a court; and
- (3) if requested by the principal, provide an accounting to the principal that, unless directed by the principal or otherwise provided in the Special Instructions, must include:
 - (A) the property belonging to the principal that has come to your knowledge or into your possession;
 - (B) each action taken or decision made by you as agent;
 - (C) a complete account of receipts, disbursements, and other actions of you as agent that includes the source and nature of each receipt, disbursement or action, with receipts of principal and income shown separately;
 - (D) a listing of all property over which you have exercised control that includes an adequate description of each asset and the asset's current value, if known to you;
 - (E) the cash balance on hand and the name and location of the depository at which the cash balance is kept;
 - (F) each known liability;
 - (G) any other information and facts known to you as necessary for a full and definite understanding of the exact condition of the property belonging to the principal; and
 - (H) all documentation regarding the principal's property.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn or any event that terminates or suspends this power of attorney or your authority under this power of attorney. An event that terminates this power of attorney or your authority to act under this power of attorney includes:

- (1) the principal's death;
- (2) the principal's revocation of this power of attorney or your authority;
- (3) the occurrence of a termination event stated in this power of attorney;

- (4) if you are married to the principal, the dissolution of your marriage by court decree of divorce or annulment or declaration that your marriage is void, unless otherwise provided in this power of attorney;
- (5) the appointment and qualification of a permanent guardian of the principal's estate unless a court order provides otherwise; or
- (6) if ordered by a court, your removal as agent (attorney in fact) under this power of attorney. An event that suspends this power of attorney is the appointment and qualification of a temporary guardian unless a court order provides otherwise.

Liability of the Agent

The authority granted to you under this power of attorney is specified in the Durable Power of Attorney Act (Subtitle P, Title 2, Estates Code). If you violate the Durable Power of Attorney Act or act beyond the authority granted, you may be liable for any damages caused by the violation or subject to prosecution for misapplication of property by a fiduciary under Chapter 32 of the Texas Penal Code.

THE AGENT, BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.