Name _____
DOB _____
Primary Care Physician _____

Advanced Podiatry of Bartlesville
234 SE DeBell Ave
Bartlesville, OK 74006

PATIENT AGREEMENT

AUTHORIZATION FOR MEDICAL TREATMENT
Clinic personnel at this facility are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION
I understand that my medical records and billing information are made and retained by this office and are accessible to office personnel. Office personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This office and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the office's charges and to any health care provider who is or may become involved with my care. Oklahoma/Kansas law requires that this office advise you that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug, substance or alcohol abuse. By signing this agreement, you are consenting to such disclosure. Office personnel may release my general condition to family or friends who inquire about me by name and are listed in the Release of Protected Health Information below.

ASSIGNMENT OF INSURANCE BENEFITS
I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

PRECERTIFICATION POLICY
I understand that this office will assist with precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY
As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this office.

CERTIFICATION
I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____ _____ _____ _____
Patient Signature (or patient's legal representative) Relationship to Patient Date Signed Witness

_____
Patient Name (please print)

RELEASE OF PROTECTED HEALTH INFORMATION
Information may be released to the following individual(s)

_____ _____ _____
Name Relationship Phone Number

_____ _____ _____
Name Relationship Phone Number

_____ _____ _____
Name Relationship Phone Number

Please check the appropriate box:
☐I authorize or ☐ do not authorize limited confidential medical messages to left on my:

Home Phone #_____ or Cell Phone #_____ or Work #_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
A complete description of how your medical information will be used and disclosed by this office is in our NOTICE OF PRIVACY PRACTICES. A copy is available in our office.
I have been made aware of the Notice of Privacy Practices.

_____ _____ _____ _____
Patient Signature (or patient's legal representative) Relationship to Patient Date Signed Witness