NORTHERN OKLAHOMA
DERMATOLOGY

PATIENT AGREEMENT

Name:_____

Date of Birth:_____

AUTHORIZATION FOR MEDICAL TREATMENT

Providers and medical staff at Northern Oklahoma Dermatology, LLC 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.
Initial_____

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Northern Oklahoma Dermatology, LLC and are accessible to office personnel. Northern Oklahoma Dermatology, LLC 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. Northern Oklahoma Dermatology, LLC and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of Northern Oklahoma Dermatology, LLC charges and to any health care provider who is or may become involved with my care. Oklahoma/Kansas law requires that Northern Oklahoma Dermatology, LLC 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. Northern Oklahoma Dermatology, LLC personnel may release my general condition to family or friends who inquire about me by name.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that physician benefits otherwise payable to the insured are to be made to the provider(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 time of service.

PRECERTIFICATION POLICY

I understand that Northern Oklahoma Dermatology, LLC will assist with insurance 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 Northern Oklahoma Dermatology, LLC. Initial_____

CERTIFICATION

I hereby certify that I have read each of the above statements, and if needed, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or I am 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/Legal Representative (Signature)	Relationship to Patient	Date	Witness

Patient Name (Please print)	Account #

RELEASE OF PROTECTED HEALTH INFORMATION:

Information may be released to the following individual(s)

Name	Relationship	Phone #
Name	Relationship	Phone #

Please check the appropriate box: ▢ I authorize **OR** ▢ I do NOT authorize limited confidential medical messages to be left on my:

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

_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Northern Oklahoma Dermatology, LLC is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted in this office/practice and can also be found on our website.

I have received a copy of NOTICE OF PRIVACY PRACTICES.

Patient/Legal Representative (Signature)	Relationship to Patient	Date Signed	Witness