**Patient Agreement**

**Authorization for Medical Treatment**

Greenwood Healthcare Specialists for Women, PLLC 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 Greenwood Healthcare Specialists for Women, PLLC and are accessible to office personnel. Greenwood Healthcare Specialists for Women, PLLC 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. Greenwood Healthcare Specialists for Women, PLLC 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 Greenwood Healthcare Specialists for Women, PLLC’s charges and to any health care provider who is or may become involved with my care. **Oklahoma law requires that Greenwood Healthcare Specialists for Women, PLLC advise you that the information authorized for disclosure may include information regarding communicable or venereal diseases including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosures.**

**Assignment of Insurance Benefits**

I agree the physician benefits otherwise payable to the insured are to be made to the physician(s) responsible for my care. Any payment received for the 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 Greenwood Healthcare Specialists for Women, PLLC will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact it may have on insurance payments.**

**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 Greenwood Healthcare Specialists for Women, PLLC.

**Certification**

I hereby certify that I have read each of the above statements, 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 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

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Patient/Patient’s Legal Representative Relationship to Patient Date Witness Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print or Type) Patient Account Number

**Release of Protected Health Information**

**Information may be released to the following individual(s)** (it is suggested that you provide at least one person, in case of emergency, that we may release information to about you):

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Name Name

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Relationship to Patient Relationship to Patient

**Acknowledgement of notice of privacy practices**

**A complete description of how your medical information will be used and disclosed by Greenwood Healthcare Specialists for Women, PLLC is in our NOTICE OF PRIVACY PRACTICES, which you have been offered. A copy is available in the office.**

**I have received/been offered a copy of the Notice of Privacy Practices.**

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Patient/Patient’s Legal Relationship to Patient Date Witness Signature

Representative