PRIMARY CARE ASSOCIATES PC

4150 SE Adams Rd. · Bartlesville, OK 74006
(918) 331-9979 · FAX (918) 331-2399

PATIENT AGREEMENT

AUTHORIZATION FOR MEDICAL TREATMENT
Primary Care Associates, hereafter referred to as 'Practice', 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 Practice and are accessible to office personnel. Practice 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 Practice 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 Practice charges and to any health care provider who is or may become involved with my care. **Oklahoma law requires that this Practice advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.** Practice 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 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 Practice 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 this Practice. A copy of the Financial Responsibility is posted in our office.

CERTIFICATION
I hereby certify that I have read each of the above statements, have had each of them 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 the Patient Agreement. A photocopy of this document has the same effect as the original.

Patient's Name	Date of Birth		
Signature of Patient or Patient's Legal Representative	Relationship to Patient	Date Signed	Witness

RELEASE OF PROTECTED HEALTH INFORMATION

☐ Prescriptions ☐ Medical Records ☐ Billing Information may be released to the following individual(s):

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

I authorize confidential medical messages to be left on:
___ my answering machine at home – Phone # _____
___ my answering machine at work – Phone # _____
___ with person/people indicated above – Phone # _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
A complete description of how your medical information will be used and disclosed by this Practice is in our NOTICE OF PRIVACY PRACTICES, which you have received.
I have received a copy of NOTICE OF PRIVACY PRACTICES

Patient or Patient's Legal Representative	Relationship to Patient	Date Signed	Witness