PATIENT AGREEMENT

Obstetrics & Gynecology

PRINT PATIENT NAME: _____ **PATIENT DOB**_____

AUTHORIZATION FOR MEDICAL TREATMENT

The Women's Health Group and its Medical Staff are hereby authorized to administer any medical, diagnostic or therapeutic treatment, including blood transfusions, 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. I understand that emergency professional services shall be provided by a specifically requested private physician or by the nearest Emergency Room, or a group of physicians engaged in the private practice of emergency medicine.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by The Women's Health Group (TWHG) and are accessible to TWHG personnel and medical staff. TWHG personnel and physicians in attendance may use and disclose medical information for TWHG operations and functions and to any other physician or health care personnel involved in my continuum of care for this admission. Safeguards are in place to discourage improper access. The Women's Health Group 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 TWHG charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that TWHG 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.**

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance benefits for The Women's Health Group charges payable to the insured are to be made payable to The Women's Health Group and that physician benefits otherwise payable to the insured are to be made payable to the physicians(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.

PRECERTIFICATION POLICY

I understand that The Women's Health Group will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, 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 me, payment is guaranteed for any amount due for such services provided by The Women's Health Group. TWHG charges for services and goods shall be at The Women's Health Group's billed charge rates unless otherwise agreed to in writing by The Women's Health Group.

RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Information may be released to the following individual(s)

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

I understand:

I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature.

CERTIFICATION

I hereby certify that I have read each of the above statements, and have had each item explained to me to my satisfaction. 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 has an original.

Patient's or Responsible Party Signature	Relationship	Date Signed

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. A copy is posted within the clinic.

I have received a copy of The Women's Health Group's Notice of Privacy Practices.

Patient's or Responsible Party Signature	Relationship	Date Signed

Witness_____ Basis for refusal, if refused:_____