Patient Name: ______________________________

DOB: ______________________________________

HIPAA AGREEMENT

Authorization for Medical Treatment
Pediatric Specialists of Tulsa personnel 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 Medical Information
I understand that my medical records and billing information are made and retained by Pediatric Specialists of Tulsa (PSOT) and are accessible to office personnel as needed to perform their respective job duties. PSOT may use and disclose medical information for operations, functions and to other physician or healthcare personnel involved in my continuum of care. Safeguards are in place to discourage improper access to my PHI. PSOT and its Personnel 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 PSOT's charges and to any healthcare provider who is or may become involved with my care. Oklahoma law requires that PSOT advise you that the information authorized for use of 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.

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 time of service.

Pre-certification Policy
I understand that PSOT will assist with insurance pre-certification requirements, but will not assume responsibility for pre-certification 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 PSOT.

Certification
I hereby certify that I have read each of the above statements. I have had each item explained to me to my satisfaction, and have been offered a copy of this form. 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.

Acknowledgment of Notice of Privacy Practices and Consent:
A complete description of how your medical information will be used and disclosed by PSOT is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement. A copy is available to you upon registration and is posted in PSOT facility.

By signing this agreement, I acknowledge receipt of PSOT's Notice of Privacy Practices and authorize the use and disclosure of my medical information as described in the Notice of Privacy Practices.

____ ______________________________
Signature of Patient or Responsible Party Date

____ ______________________________
Relation to patient if different Witness

Basis for refusal if refused: ____