

UPPER EXTREMITY HAND & MICROSURGERY CENTER
3366 NW Expressway, Suite 700, Oklahoma City, OK 73112 Phone: (405) 945-4888

I, _____ recognize and acknowledge that ALL charges or co-pays for treatment and/or diagnosis are due and payable *at the time of service*. (With the exception of approved workers comp services provided.) If other arrangements are necessary, please discuss this with the receptionist PRIOR to your treatment/diagnosis.

To help us with filing your insurance, we need the following:

- Insurance company claim forms (only if required by your company)
- Policy numbers (group and identification)
- Mailing address to mail the claim
- Phone numbers (to verify coverage/second opinion, etc)
- Employees or insureds statement (please fill in and sign)
- Name, social, and birth date of insured (if not patient)

PLEASE BE ADVISED:

Insurance companies are responsible only to you, the insured, and not the doctor. Although we will make every effort to facilitate your insurance billing, the patient/insured party is **ULTIMATELY RESPONSIBLE FOR THE TOTAL CHARGES INCURRED**. Thank you for your time and consideration.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I understand that as part of my health and medical care, the center originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I further understand this information serves as:

- a basis for planning my care and treatment
- a means of communicating among the health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bills
- a means for a third party payor to verify that services were billed as actually provided.
- A tool for routine operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing. I understand and have been provided with a **Patient Privacy Notice** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **Patient Privacy Notice** prior to signing this consent. I understand that the center reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the center is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you...that the information authorized for release may include records which may indicate the presence of influenza, a communicable or venereal disease which may include, but are not limited to, disease such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as AIDS.

In addition to the release outlined above, information may be released to the following individuals for the indicated purposes.

I requested the following restrictions to the use and or disclosure of my health information: _____

I authorize Dr. Rayan to take pictures of my hand for educational purposes. YES _____ NO _____

Signature: _____

Date: _____