

Patient Name: _____

Date of Birth: _____

Authorization for Medical Treatment

I, the undersigned, authorize Victor T. Wilson, M.D., P.C., (hereinafter "The Clinic") and its Medical Staff to administer to the patient any medical, diagnostic or therapeutic treatment as is necessary. I acknowledge that no guarantees have been made as to the result of the treatment or examination. I further understand that the physician or provider may order an HIV Antibody (AIDS) test as part of diagnosis and treatment. I also understand that 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 The Clinic, and are accessible to its personnel and medical staff. Employed personnel and physicians in attendance may use and disclose medical information for treatment, payment, and health care operations to any other physician or health care personnel involved in my course of care. Safeguards are in place to discourage improper access. The Clinic and its medical staff are authorized to disclose all or part of the patient's medical record to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of The Clinic's charges and to any health care provider who is or may become involved with the patient's care. I further consent to the release of information as necessary for payment and health care operations. Oklahoma law requires that The Clinic advise you that information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to: Hepatitis, Syphilis, Gonorrhoea, Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (AIDS). By signing this agreement you are consenting to such disclosure.

Release of Responsibility

The Clinic is hereby released from any responsibility for any items or personal property brought onto The Clinic premises.

Financial Agreement and Assignment of Benefits

For services rendered to the patient, I assign and authorize payment to The Clinic of any health care insurance benefits including Major Medical Benefits. Physician or provider benefits otherwise payable to the insured are to be made payable to the physician responsible for my care. I understand that I am responsible for and guarantee payment of any health insurance deductibles and any remaining reasonable charges after Title XVIII payment. I fully understand that this bill is subject to any charges and/or credits not available at the time care is rendered, as well as changes in the estimated insurance benefits, fees, and court costs related to collection of this account.

I hereby certify that I have read each of the above statements, and have had them explained to me to my satisfaction, and accept the terms herein. I further certify that I am the parent or guardian of the patient and am duly authorized to accept these terms on his or her behalf. A photocopy or digital image of this shall be considered the same as the original.

Parent or Guardian Signature

Date

Relationship

Witness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how the patient's medical information will be used and disclosed by The Clinic is in our Notice of Privacy Practices, which I have received a copy of and read before signing this acknowledgement.

Parent or Guardian Signature

Date

Relationship

Witness