RICHARD M. ALBERTSON, M.D.
2120 W. ELK, STE. 6
DUNCAN, OK 73533

DATE:_____

PATIENT NAME:

FIRST _____MIDDLE_____LAST_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUSINESS/OTHER PHONE _____ SOCIAL SEC. NO. _____

DATE OF BIRTH _____ AGE _____ SEX _____ MARITAL STATUS _____

RACE: Caucasian____ American Indian____ Black____ Other____ Pacific Islander____ Asian____ Declined____

ETHNICITY: Non-Hispanic____ Hispanic____ Declined____

LANGUAGE: English____ Spanish____ Other____ Arabic____ Cantonese____ French____ German____ Hindi____

REFERRED BY _____CITY/STATE_____

PERSONAL PHYSICIAN _____CITY/STATE_____

PHARMACY _____

PATIENTS EMPLOYER _____

ADDRESS_____ PHONE_____

SPOUSES NAME _____ SPOUSES EMPLOYER _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

NAME _____ RELATIONSHIP _____

ADDRESS _____ HOME PHONE _____

EMPLOYER _____ BUSINESS PHONE _____

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Heath Care Operations

Initial X_____I understand that as part of my health and medical care, RICHARD M. ALBERTSON, M.D. originates and maintains medical and health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. This information is also referred to as protected health information. I understand that this information serves as:

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

Initial X_____I hereby consent to the use of this information for purposes of my treatment, my payment obligations and Clinic's health care operations. I understand that this agreement to use and disclose my protected health information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement shall remain in force until such time as I shall revoke it in writing.

Initial X_____I further understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of uses and disclosures of my protected health information. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that DR. ALBERTSON reserves the right to change his notice and practices, and that a copy of the revised notice will be made available upon request. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that DR. ALBERTSON is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, and that the Clinic will honor the revocation except to the extent the organization has already taken action in the reliance thereon.

Initial X _____By Oklahoma law we are required to notify you **… that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

A. **Consent for Treatment:** I give consent to my physician, other attending physicians and their assistants and designees, to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures and all medical treatment rendered at my physician's office under his instruction; including x-ray, laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues, and/or parts may be removed from my body. I authorize my physician and his personnel to send the specimen to the lab of his choice when necessary in obtaining a diagnosis and authorize him and his personnel to dispose of any non-concerning cells, tissues, or parts that are removed.

B. **General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results of my examinations or treatments. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.

C. **Assignment and Agreement to Pay:** I understand that I am responsible for payment of the services I receive and guarantee payment for these services. I hereby assign to the physicians, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third party payer arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of physicians and/or the professionals associated with an office practice. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. In addition, I understand that I may receive separate bills from independent physicians involved in my care; including radiologists, anesthesiologists, pathologists, emergency room physicians, other independent physicians, and Duncan Regional Hospital. These physicians and organizations may or may not participate in all insurance networks. I authorize payment directly to the undersigned physician for benefits otherwise payable to me for his services as coded.

D. **Insurance Acknowledgment:** I acknowledge that it is my responsibility to understand the benefits of my insurance plan and it's requirements when seeking treatment and/or care not provided by my primary care provider.

E. **Pre-certification:** I understand that it is my responsibility to contact my insurance company to determine if a pre-certification/prior authorization is needed for an upcoming procedure or service. I understand that if a pre-certification/prior authorization is required it is my responsibility to notify the office prior to the procedure date. (Some insurance companies require a notification 3-5 days in advance. If pre-certification is not obtained I understand that a penalty my be assessed by my insurance company.

F. **Privacy Notice:** I acknowledge that a copy of the Notice of Privacy Practices was available for me. Please refer to the Notice of Privacy Practices for more information regarding releases of your health information and your right to access your health information.

*******You may leave (appointment reminders, medical information) on my message service or machine. Yes_____No_____**

Release of my medical information may be released to (family members, friends, etc.): **All Medical Records will be released to other physicians.

_____ _____ _____

X_____ _____

Signature of Patient or Legal Representative **Date Notice**

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OFFICE USE ONLY:

Richard M. Albertson, M.D. _____ accepts _____ denies conditionally the restrictions imposed on release of information as stated above.

_____ _____

Signature/Title **Date**

Name:_____ **Date:**_____

Referring Physician:_____

Primary Care Physician:_____

Reason for Visit:

Previous Medical History

Major Illnesses:

_____

_____

_____

_____

Surgeries or Procedures:

_____

_____

_____

_____

_____

Medicine

(Taken on a daily basis)

_____

_____

_____

_____

_____

Allergies to Medications:

_____

_____

_____

Social History

Marital status-Please Check

Married____ Single____ Divorced____ Widowed____ Separated_____

Occupation _____ Exercise _____

Education _____

Family History Age/Illness

Mother _____

Father _____

Siblings _____

Children _____

Smoking Status-Please Check

None ____

Current Smoker____Daily Use_____

Former Smoker ____Year Quit _____

Smokeless Tobacco User ____

Alcohol-Please Check

None____ Rare_____ Occasional_____

Current Drinker_____ Former Drinker____

Alcohol Dependency_____

Do you have problems with anesthesia? _____

Do you have bleeding problems?_____