OU PHYSICIANS
COMPREHENSIVE PATIENT CARE CONSENT AND ACKNOWLEDGEMENTS

I understand that this OU Physicians Comprehensive Patient Care Consent & Acknowledgements applies to my or my minor child's visits (referred to together as "I" and "my"), at all OU Physicians locations.

Initial each item to indicate your understanding and agreement.

GENERAL CONSENT FOR TREATMENT: I voluntarily consent to receive care encompassing physical examinations, diagnostic procedures, and medical treatment by an OU Physicians provider and/or staff member for myself or minor child.

__________Initial

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS:
I understand that OU Physicians will release information to my insurance company or responsible party necessary to secure payment for services rendered, and I assign payment of insurance benefits to OU Physicians and other providers for such services. (If I am an OU student, I consent to the release of my treatment & education records to my insurance company for payment for services rendered and authorize the company to pay OU Physicians and other providers for such services.)

__________Initial

FINANCIAL AGREEMENT AND PAYMENT RESPONSIBILITY: I acknowledge that I am responsible for all charges incurred, regardless of insurance status. Copays, and co-insurance if applicable, are due at the time of service. I understand the co-pay, and co-insurance if applicable, amount is expected at this time and will be collected. I agree to pay for services as they are provided and/or pay the balance due promptly upon receipt of a statement. I have received a copy of and agree to OU Physicians' Patient Rights and Responsibilities.

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PRESCRIPTIONS: I consent to OU Physicians accessing prescription databases to review my prior and ongoing prescription history. I may revoke this consent by notifying OU Physicians in writing. If I do not provide consent or if I revoke this consent, I may be terminated as an OU Physicians patient.

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APPOINTMENT/REFILL REMINDERS: OU Physicians providers want to assure that they effectively communicate with their patients. I have been advised that OU Physicians clinics may provide appointment and refill reminders via mail, secure email or patient portal, text, and automated or live telephone messages. I understand that text messages may not be encrypted, so it's possible for them to be viewed by unauthorized individuals.

_________Initial

OU Physicians

EDUCATION, FEEDBACK, EVENTS, ETC., COMMUNICATIONS: OU Physicians may send me health-related educational materials; patient experience surveys; requests for completion of my medical, social, and family history information to facilitate care; notices about special events for patients and family members such as camps and classes; and recognition of special milestones. I understand that these types of communications may be made by phone, secure email, mail, patient portal, and text messaging. Text messages may not be encrypted, so it's possible for them to be viewed by unauthorized individuals.

__________**Initial**

LEAVING MESSAGES: I understand there are times when OU Physicians may not be able to reach me. OU Physicians may leave a message that includes information about my health.

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Behavioral Health Clinic Observation, Examination, and Treatment by OUHSC Students and Trainees:
I understand that the Behavioral Health Clinic is part of the College of Medicine of the OUHSC and that if I am a patient in the Behavioral Health Clinic, I may be examined and treated by students under supervision as part of their educational program. These examinations and this treatment may be observed directly or by the use of one-way mirror or closed- circuit television for training and supervision purposes. Those observing may be faculty members, trainees, or students, and I understand that I will be informed if observation is involved. I understand that faculty members, trainees, students, will also have access to counseling and psychiatric records for training purposes and such access is only permitted under supervision.

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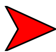
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: The Notice tells me how OU will use my health information for the purposes of my treatment, payment for my treatment, and OU's health care operations. The Notice explains in detail how OU may use and share my health information for purposes other than treatment, payment, and health care operations. OU will also use and share my health information as required/permitted by law. (If I am an OU student receiving student health services, I consent to OU using and disclosing my treatment and education records it maintains for the purposes in OU's Notice of Privacy Practices.)I have received this Notice.

__________**Initial**

I understand the information in these Comprehensive Patient Care Consent and Acknowledgements items and I have had an opportunity to ask questions and have had my questions answered. I understand that these items are effective indefinitely unless revoked.



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Signature of Patient or Legally Authorized Representative* **Date**

Printed Name of Patient: ____________________________

**May be requested to show proof of representative status.*