



# OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

## PATIENT AGREEMENT

### DISCLOSURE OF INFORMATION

I understand that my medical and billing records are maintained by Oklahoma Cancer Specialists and Research Institute (OCSRI) and are accessible to personnel. OCSRI personnel may use and disclose medical information for treatment, payment or operations to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. OCSRI 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 the services rendered. Oklahoma law requires OCSRI to advise you that the **information authorized for use or disclosure may include information which may indicate the presences 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. \_\_\_\_\_

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### ASSIGNMENT OF INSURANCE BENEFITS

My rights to payment for all drugs, procedures, tests, equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to OCSRI. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurances and any other health plans. I acknowledge this document as a legally binding assignment/agreement to collect my benefits as payment representative; I will endorse such payments to OCSRI. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit care at the time of service. \_\_\_\_\_

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### FINANCIAL RESPONSIBILITY

I acknowledge I have received, understand and agree to the terms listed in the OCSRI's Financial Policy. \_\_\_\_\_

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### ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge I have received, read and understand my Patient Rights and Responsibilities. \_\_\_\_\_

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### CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient, or Legal Representative for the patient, and I accept the terms of this patient Agreement. A photocopy of this document has the same effect as an original.

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_  
(if applicable)

Printed Name: \_\_\_\_\_

Account Number: \_\_\_\_\_ Date: \_\_\_\_\_

### ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by OCSRI is in our **NOTICE OF PRIVACY PRACTICES**, which you have received.

I have received a copy of the **Notice of Privacy Practices**.

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_  
(if applicable)

Date: \_\_\_\_\_