



**ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND
PATIENT AGREEMENTS RELATED TO TREATMENT**

The Scholl Center for Communication Disorders
4415 S. Harvard Ave, Ste 125; Tulsa, OK 74135
918-508-7601 Fax-918-442-2980

CONSENT FOR ROUTINE MEDICAL TREATMENT

The Scholl Center for Communication Disorders, P.L.L.C. and its employees are here by authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by The Scholl Center for Communication Disorders, P.L.L.C. and are accessible to its personnel and medical staff for use in my care. The Scholl Center for Communication Disorders, P.L.L.C. personnel and physicians may use and disclose information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. The Scholl Center for Communication Disorders, P.L.L.C. is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of The Scholl Center for Communication Disorders, P.L.L.C. charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to The Scholl Center for Communication Disorders, P.L.L.C. , except to the extent we have already acted in reliance on it.

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for The Scholl Center for Communication Disorders, P.L.L.C. charges payable to the insured are to be made payable to The Scholl Center for Communication Disorders, P.L.L.C. and that insurance benefits for services provided by the physicians in the hospital setting otherwise payable to the insured are to be made payable to the physician(s) responsible for you care. Any payment received for this episode of care may be applied to any unpaid bill for which you are liable, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

You understand that The Scholl Center for Communication Disorders, P.L.L.C. will assist with insurance precertification requirements which are the responsibility of the policyholder and/or the hospital, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINICIAL RESPONSIBILITY

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by The Scholl Center for Communication Disorders, P.L.L.C. Charges for services and goods shall be at The Scholl Center for Communication Disorders, P.L.L.C. billed charges unless otherwise agreed to in writing by The Scholl Center for Communication Disorders, P.L.L.C.

PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as the original.

Signature of Patient of Patient's Legally Authorized Representative (Documentation Must Be Provided)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by The Scholl Center for Communication Disorders, P.L.L.C. is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgement. The Notice is posted throughout our office and you will be given a copy for your personal use.

I have received a copy of The Scholl Center for Communication Disorders, P.L.L.C. Notice of Privacy Practices:

Patient or Representative

Legal Authority of Representative

Date Signed

Basis for refusal, if refused: _____