KIAMICHI
FAMILY MEDICAL CENTER

PATIENT AGREEMENTS AND ACKNOWLEDGEMENT

AUTHORIZATION FOR MEDICAL TREATMENT

Kiamichi Family Medical Center, Inc. (KFMC) and its personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I represent to KFMC that I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance or medical benefits for KFMC's charges otherwise payable to me are to be made payable to KFMC. Any payment received for services may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

PRECERTIFICATION

I understand that KFMC will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided me, payment is guaranteed for any amount due for such services provided by KFMC. Charges for services and goods shall be at KFMC's billed charges rates unless otherwise agreed to in writing by KFMC. Past due is defined as any balance outstanding after 30 days from initial billing date.

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 received a copy of the Notice of Privacy Practices and this Patient Agreement and Acknowledgement. I further certify that I am the patient or duly authorized by the patient to accept the terms of the Patient Agreement and Acknowledgement. A photocopy of this document has the same effect has an original.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by KFMC and are accessible to KFMC personnel as needed to perform their respective job duties. KFMC personnel in attendance may use and disclose medical information for operational purposes and to any other physician or health care provider involved in my continuum of care. Safeguards are in place to discourage improper access to my protected health information. KFMC and its personnel are authorized to disclose all or part of my medical record to any insurance carrier or health plan, workers compensation carrier, or self-insured employer group liable for any part of KFMC's charges and to any health care provider who is or may become involved with my care.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

A complete description of how your medical information will be used and disclosed by KFMC is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement. A copy is available to you upon registration and is posted in KFMC facilities.

By signing this agreement I acknowledge receipt of KFMC's Notice of Privacy Practices and authorize the use and disclosure of my medical information as described in the Notice of Privacy Practices.

Patient or Responsible Party	Relationship	Date Signed	Witness

Updated 2-2014