Stillwater Medical Center
CLINICS

REGISTRATION

Patient Name (Last, First, Middle): _____

SSN: _____-_____-_____ Birth Date: _____/_____/_____ Sex: Female

Billing Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Life Partner

Race: Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language: _____ Religion: _____

Primary Care Physician: _____ Local pharmacy: _____

Mail order pharmacy: _____

Home phone: _____ Cell phone: _____

Email address: _____ *Patient portal and survey reasons only

Employer _____

EMERGENCY CONTACT

Name: _____ Phone: _____

GUARANTOR (if patient is a minor)

Name: _____ Relationship to patient: _____

Birth Date: ____/____/_____ Home phone: _____ Cell phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I request payment of authorized Medicare and/or commercial insurance benefits to me or on my behalf for any services furnished me by or in SMC. I authorize any holder of medical or other information about me to release to Medicare and/or commercial insurance and its agents any information needed to determine these benefits or benefits for related services. A photocopy of this release shall be considered effective and as valid as the original.

Payment in full may be required at the time of service. For your convenience, we accept personal checks, credit card, and cash. Any medical insurance you may have is intended to protect you against financial loss, but payment in full for your care is your responsibility regardless of insurance coverage.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or the liability of another party. I will make sure that my claims are paid promptly. A photocopy of this release shall be considered effective and as valid as the original.

Signature Patient/Guarantor/Guardian: Date:

- **CONSENT FOR CARE**
  I, or my representative, hereby consent to medical treatment, diagnostic and/or therapeutic services as ordered by my physician and his/her designee(s). I further understand that my physician may order an HIV antibody (AIDS) test as part of diagnosis and treatment.

  If I am an obstetrical patient admitted to the hospital for the delivery of my baby, I also consent to hospital care of my infant(s) encompassing diagnostic procedures, including but not limited to laboratory testing, and medical treatment.

  I understand that care may be provided to me by students performing under the supervision of hospital or medical staff.

  I understand that photographs or video may be used for identification purposes and to aid in or document my treatment. Photographs in the medical record will be handled according to customary medical record privacy practices.

  I understand that with the exception of physicians employed by the hospital, the physicians on staff at Stillwater Medical Center, such as emergency room physicians, radiologists, anesthesiologists, and pathologists are not employees or agents of the hospital but are independent contractors/agents who have been granted privileges to use the hospital facilities.

- **AUTHORIZATION TO RELEASE/OBTAIN INFORMATION FOR TREATMENT, PAYMENT, OR OPERATIONS; TO MY PATIENT PORTAL AND THE HEALTH INFORMATION EXCHANGE**
  I am aware that medical information will be released or obtained in order to get assistance in continued medical treatment, paying of bills or other routine operations of the hospital; to my patient portal and health information exchange. The information authorized for release may include records which may indicate the presence of a communicable disease or non-communicable disease. I have received a copy of the Notice of Information Practices (Privacy Notice) that describes how this information is used and may request another copy at any time**.**

- **AUTHORIZATION TO CONTACT**
  I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or emails, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services.

- **INSURANCE PRE−CERTIFICATION**
  I hereby expressly understand I am responsible for notification to my insurance company to obtain authorization before service is rendered. I understand if this is not done, insurance benefits may be reduced.

- **VALUABLES AND PERSONAL BELONGINGS**
  Stillwater Medical Center is not responsible for personal valuables left at the bedside or retained on the person. This includes, but is not limited to electronic equipment, glasses, dentures, hearing or other prosthetic devices. (A HOSPITAL SAFE IS AVAILABLE FOR DEPOSIT OF VALUABLES UPON REQUEST).

- **PATIENT RIGHTS**
  I have read and received a copy of the Patient Rights. Patient Rights are posted in the Patients and Visitors Handbook available in each inpatient room and all outpatient−waiting areas.

- **ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, THIRD PARTY LIABILITY/AND BILLING**
  I, or legal guardian, assign and transfer all benefits, monies, and sums payable for hospitalization, sickness or accident under any hospitalization, (including major medical and supplemental benefits), sickness or accident policy providing for hospital payment.

  I, or legal guardian, will be responsible for any amount due in consideration of services rendered at Stillwater Medical Center. Amounts estimated or known to be payable by the patient become due and payable at the time of discharge (including, but not limited to, non−covered services, health insurance deductible, and coinsurance amounts). This includes hospital−based physicians and contractual physician services that may bill separately for their professional services.

  If this service is for treatment of an injury, illness or condition which may have been caused by a third party, for which that third party is, or may be liable for damages, the patient agrees to give the hospital a lien, up to the amount of the outstanding charges, on any recovery the patient makes from the third party of any uninsured or underinsured motorist coverage of the patient, the patient's parents, patient's spouse, or patient's guardian. The patient further agrees that if there is no third party recovery or recovery from uninsured or underinsured motorist coverage, the patient, or legal guardian is still responsible for payment of the outstanding charges.

- **MEDICARE ASSIGNMENT OF BENEFITS**
  I, or representative, certify the information given in applying for payment under Title XVIII of the Social Security Act is correct. Release of information related to this Medicare claim to the Social Security Administration or its intermediaries and carriers is authorized. Request of payment of authorized benefits to Stillwater Medical Center is authorized.

- **MSG−−MEDICARE MESSAGE (Medicare Inpatient Only)**
  The federal government requires we provide to you written information regarding your rights as a Medicare hospital patient. You will receive information that includes the procedure for initiation, review, and resolution of complaints.

- **MSP QUESTIONNAIRE (Medicare Secondary Payor)**
  The government requires we request additional information from you to determine if there is any other resource for payment that could be primary to Medicare.

The undersigned certifies that he/she has read the above information or it has been explained so that he/she understands. Signatures also indicate he/she has been offered information on privacy and patient rights, including the procedure for initiation of complaints:

SIGNATURE OF PATIENT OR REPRESENTATIVE:	RELATIONSHIP TO PATIENT:	WITNESS:
RESPONSIBLE PARTY/INSURED (if different):	RELATIONSHIP TO PATIENT:	DATE:

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Stillwater Medical Center clinics, originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further 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
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the right to review the NOTICE OF INFORMATION PRACTICES prior to signing this consent. I understand that Stillwater Medical Center reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. 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 healthcare operations and that Stillwater Medical Center is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma State 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).

In addition to the releases outlined above, information may be released to the following individuals/organizations for the indicated purpose:

_____

I request the following restrictions to the use and/or disclosure of my health information:

_____

(Please check one) You ☐ may ☐ may not leave appointment reminders and/or medical information with my message service, voicemail, or on my answering machine.

_____ _____

Signature of Patient or Legal Representative Date Notice Effective

Stillwater Medical
Urgent Care & Occupational Medicine

518 E Lakeview Rd, Stillwater, OK 74074
405.533.8990

Reason for today's visit:

How long have you had these symptoms?

If injury, explain briefly:

Date/time of injury:

Is the injury work related? ☐ Yes ☐ No

Please list all medications you are currently taking:

Please list all medications you are allergic to:

Signature: Date:

Click here to submit: **Submit**