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BISCHOFF

HAND SURGERY

ASSIGNMENT & CONSENT

Printed Name: _____

Authorization to Pay Benefits to Physician(s): I hereby assign payment directly to Bischoff Hand Surgery for the surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed my indebtedness to said physician and / or surgeon for those services. I understand that I am financially responsible for the charges incurred by the patient named above.

_____ _____

Signed (Patient, Parent, or Authorized Party) *Date*

Consent for Treatment and Release: I hereby give Bischoff Hand Surgery consent to treat me and to release any information required in the course of my examination or treatment to my referring doctor, my insurance company, and/or treating healthcare entities or providers. I understand that this release covers multiple requests for such information by my referring doctor, my insurance company and/or other treating healthcare entities or providers, and that this release authorizes BHS to respond to suck requests. I give consent for Bischoff Hand Surgery to use e-prescribing tools to obtain my medical history. I understand that if I decline, I will not be able to receive prescriptions from Bischoff Hand Surgery.

Per 63 O.S.§ 1-502.2, all requests for medical records must contain the following language: **I understand that my medical records may contain information that indicates that I have communicable or non – communicable disease. I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse**.

_____ _____

Signed (Patient, Parent, or Authorized Party) *Date*

Work Comp: I hereby give Bischoff Hand Surgery consent to release to _____ my employer, their insurance carrier or other representative, any information regarding my medical condition or treatment.

Per 63 O.S.§ 1-502.2, all requests for medical records must contain the following language: **I understand that my medical records may contain information that indicates that I have communicable or non – communicable disease. I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse**.

_____ _____

Signed (Patient, Parent, or Authorized Party) *Date*

Oklahoma Surgical Hospital

We are proud to inform you that our physician(s) at Bischoff Hand Surgery is part owner of Oklahoma Surgical Hospital, located at 2448 E. 81st street, Tulsa, Oklahoma. Your physician(s) may refer you to Oklahoma Surgical Hospital because your physician(s) believes it provides quality medical care. Oklahoma Surgical Hospital is a state-of the-art surgical hospital that is convenient for patients in terms of location, access, scheduling and hours of operation. We believe the hospital's staff provides excellent service to the patients. We recognize that you have a choice in the selection of the facility where you receive care. If you would prefer to obtain treatment at another hospital, please discuss this with your physician

Initials: _____