ASSIGNMENT & CONSENT

Printed Name: ____

Authorization to Pay Benefits to Physicians: I hereby assign payment directly to Central States Orthopedic Specialists 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 I am financially responsible for the charges incurred by the patient named above.

____ ______________________________________

Signed (Patient, Parent, or Authorized Party) Date

Consent for Treatment and Payment: I hereby give Central States Orthopedic Specialists 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 health care entities or providers, and that this release authorizes CSOS to respond to such requests. I give consent for Central States Orthopedic Specialists to use e-prescribing tools to obtain my medication history. I understand that if I decline, I will not be able to receive prescriptions from Central States Orthopedic Specialists.

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 a 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 Central States Orthopedic Specialists 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 a 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 some of the physicians at Central States Orthopedic Specialists are part owners of Oklahoma Surgical Hospital, located at 2408 E. 81st Street, Tulsa, Oklahoma. A list of these physicians is available upon request. Your physician may refer you to Oklahoma Surgical Hospital because your physician believes it provides quality medical care. Oklahoma Surgical Hospital is a state-of-the-art surgical hospital that is convenient for patient 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 with your physician.

____

Initial

Decline to Consent to Release of Medical Records

In the event you, the patient, decline to consent to release of your medical records by CSOS to your referring physician or your insurance company, you will be solely and individually responsible for picking up and delivering your medical records to all physicians or insurance companies requesting them, and for payment of such services that are denied due to insufficient records.

____ ______________________________________

Signed (Patient, Parent, or Authorized Party) Date

A photo static copy of this authorization shall be considered as valid as the original. Last modified 12/2010