PATIENT REGISTRATION FORM

Patient Name: _____ Mother's Maiden Name _____

Date of Birth: _____ Age: ____ SSN: _____ Male ☐ Female ☐ **Email Address:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell: (____) _____ Alternate: (____) _____

Race: _____ Ethnicity: _____ Language(s) _____ Religion _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse Name: _____ Phone: (____) _____ Cell: (____) _____

Next of Kin: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell: (____) _____ Alternate: (____) _____

Emergency Contact: (Not at your residence) _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell: (____) _____ Alternate: (____) _____

Employment Status: Employed FT ☐ PT ☐ Self ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐

Employer Name: _____ Occupation: _____ Work Phone: (____) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Have you been in the hospital the past 3 months? Yes ☐ No ☐ If yes, where? _____

Have you fallen in the past 3 months? Yes ☐ No ☐ Are you allergic to Latex? Yes ☐ No ☐

Responsible Party (Insurance policy holder if other than patient)

Primary Insurance Information

Name of Insured: _____ Relationship to patient: _____

Insured Date of Birth: _____ Insured SSN: _____

Insurance Name: _____ Policy Number: _____

Group Number: _____ Co-pay Amount: _____

Insured Employer Name: _____

Insured Employer Address: _____ City: _____ State: _____ Zip: _____

Insured Employer Phone Number: (____) _____

Secondary Insurance Information

Name of Insured: _____ Relationship to patient: _____

Insured Date of Birth: _____ Insured SSN: _____

Insurance Name: _____ Policy Number: _____

Group Number: _____ Co-pay Amount: _____

Insured Employer Name: _____

Insured Employer Address: _____ City: _____ State: _____ Zip: _____

Insured Employer Phone Number: (____) _____

_____ _____

Signature of patient (parent or guardian if minor) **Date Signed**

FINANCIAL STATEMENT

Please read and initial each of the following statements and sign and date below

_____ I authorize medical treatment for myself or my family member. I understand that I am responsible for all charges incurred regardless of insurance status. I understand that *the* Oklahoma Transplant Center will file my insurance, however, *the* Oklahoma Transplant Center's association is with me, the patient, not my insurance company, and I am ultimately responsible for my bill. I agree to pay my coinsurance and deductible promptly upon receipt of statement. I authorize my insurance company to pay *the* Oklahoma Transplant Center on my behalf. This assignment will remain in effect until revoked by me in writing.

_____ I understand that my eligibility coverage by _____ (name of insurance company) may not be confirmed at this time. I wish to receive medical service from *the* Oklahoma Transplant Center. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

_____ I hereby assign to *the* Oklahoma Transplant Center any insurance or third-party benefits available for health care services provided to me. I understand that *the* Oklahoma Transplant Center has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to *the* Oklahoma Transplant Center, I agree to forward to *the* Oklahoma Transplant Center all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature:_____ Date:_____
Patient

Signature:_____ Date:_____
Legally Authorized Representative

- ☐ Parent or Guardian
- ☐ Legal Authority
- ☐ Spouse

Oklahoma Transplant Center

OU Medical Center

Patient Consent Form

(Please Read and Sign Below)

I, the undersigned, hereby consent to the following treatment:

- ✓ Administration and performance of all treatments
- ✓ Administration of any needed anesthetics
- ✓ Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- ✓ Use of prescribed medication
- ✓ Performance of diagnostic procedures/tests and cultures
- ✓ Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Oklahoma Transplant Center** may include consent at satellite offices under common ownership.

I, undersigned, authorize **Oklahoma Transplant Center** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries tor my Medicare claims. I assign the benefits payable for services to **Oklahoma Transplant Center.**

I acknowledge that I have been given the Oklahoma Transplant Center Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient Initials:

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Legal Representative **Date**

Authorization to Photograph

Patient Name

Address

City State Zip

I hereby give my consent to have photographs and/or videotape and/or film and/or sound recording made of myself and/or my child and/or my physician for the purpose of patient identification that will be filed in the patient's chart.

Signature Date

Legal Guardian Signature Date

Witness Date

Physician/Provider Contacts

Referring Physician/Provider

Name _____

Address _____

_____

Phone # _____

Fax # _____

Primary Care Physician/Provider

Name _____

Address _____

_____

Phone # _____

Fax # _____

Specialist

Name _____

Address _____

_____

Phone # _____

Fax # _____

Specialist

Name _____

Address _____

_____

Phone # _____

Fax # _____

Pharmacy

Name _____

Address _____

_____

Phone # _____

Fax # _____

How did you find us?

How did you find out about our clinic? Circle answer.

1. **Newspaper/Magazine (circle one)**
    a. **If known, specify the name of newspaper/magazine:** _____
2. **Television/Radio (circle)**
    a. **If known, specify the station name:** _____
3. **Web Page**
4. **Physician Referral Name:**
    a. **If known, specify physician name:** _____
5. **Friend/Family Member/Other (circle one):**
    a. **If known, specify name:** _____

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Last Four Digits SSN *(optional)*:**
Provider's Name: OKLAHOMA TRANSPLANT CENTER, OU Medical Center	**Recipient's Name:**	
	Address 1:	
Provider's Address: Oklahoma Transplant Center OU Medical Center, 940 NE 13th Street, Suite 3000, Oklahoma City, Oklahoma 73104, OFC - 405-271-7498 Fax - 405-271-4329	**Address 2:**	
	City: / **State:** / **Zip:**	
	Phone Number (Starting with area code)	

Request Delivery (If left blank, a paper copy will be provided): ☐ Paper Copy ☐ Electronic Media, if available (*e.g.*, USB drive, CD/DVD) ☐ Encrypted ☐ Unencrypted Email **NOTE:** In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). **There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g. virus) potentially introduced to your computer device when receiving PHI in an electronic format or email.**

Email Address (If Electronic Media checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **180 Days** **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

EDEMF6121 PNJETPP016 12/10/2020 15:14 IN29120

Oklahoma Transplant Center

Anthony Sebastian, M.D. Alan Hawxby, M.D. Rajesh Kanagala, M.D.
Harlan Wright, M.D. Terry Green, ARNP

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, Oklahoma Transplant Center 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 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 PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Oklahoma Transplant 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 Oklahoma Transplant 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 law we are required to notify you… that the information authorized for release may include records which may require 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 release outlined on the front page, information may be released to the following individuals (family members, etc.) for the indicated purpose:

_____ _____

_____ _____

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

_____

_____

May we leave Health Information on your answering machine/ voice mail? ☐ yes ☐ no

_____ _____

Signature of Patient or Legal Representative **Date Notice Effective**

Oklahoma Transplant Center ☐ accepts ☐ denies ☐ accepts conditionally

the restrictions imposed on release of information as stated above.

_____ _____

Signature/ Title Date

Oklahoma Transplant Center
940 NE 13th Street, Suite 2000 Oklahoma City, OK 73104 ❖ Telephone 405-271-7498 ❖ Fax 405-271-4328

TPLS
OTC - HIPPA CONSENT-LIVER

BLANK,PATIENT
Acct # MR#
Loc: DOB: