

PLEASE PRINT

|                           |  |
|---------------------------|--|
| OFFICE USE ONLY: INITIALS |  |
| ACCOUNT #                 |  |

**PATIENT INFORMATION**

|   |                     |   |  |   |
|---|---------------------|---|--|---|
| Date  | Referring Physician |   | Referring Physician Phone                                    |   |
| Last  | First               | Middle  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F |   |
| Address   |                     | City  | State  | Zip   |
| Home Telephone<br>( )   | Age                 | Birthdate / /   | Marital Status<br>S M W D DEP                                |   |
| Race:<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Hispanic<br><input type="checkbox"/> Pacific Islander                                     |                     | Ethnicity:<br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Non-Hispanic or Non-Latino          |  | Religion: _____   |
| <input type="checkbox"/> African American<br><input type="checkbox"/> Caucasian<br><input type="checkbox"/> Native American<br><input type="checkbox"/> Other |                     | Language:<br><input type="checkbox"/> English<br><input type="checkbox"/> Spanish<br><input type="checkbox"/> Other _____ |  | Interpreter needed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employer  | Address             |   | City   | State Zip   |
| Work Phone & Ext.<br>( )  | Cell Phone          | Pager   | E-Mail   | May we contact you through email?<br>Yes No                                     |
| Next of Kin (NOK)   |                     | Relation  | Home Phone<br>( )  | Work Phone & Ext.<br>( )  |
| Emergency Contact (EMC)   |                     | Relation  | Home Phone<br>( )  | Work Phone & Ext.<br>( )  |

**SPOUSE/PARENT INFORMATION**

|               |                     |               |                       |                          |
|---------------|---------------------|---------------|-----------------------|--------------------------|
| Spouse/Parent | Relation to Patient |               | Home Telephone<br>( ) |                          |
| Address       |                     | City          | State                 | Zip                      |
| Employer      | SS# - -             | Birthdate / / | Age                   | Work Phone & Ext.<br>( ) |

**WORKERS COMPENSATION INFORMATION**

|                        |  |                         |
|------------------------|--|-------------------------|
| Employer Name          |  | Employer Phone #<br>( ) |
| Date of Injury         |  |                         |
| Description of Injury  |  |                         |
| Work Comp Carrier Name |  | Claim #                 |
| Address                |  | Phone #<br>( )          |
| Name of Adjuster       |  | Phone #<br>( )          |
| Attorney Name          |  |                         |
| Address                |  | Phone #<br>( )          |

**OTHER INFORMATION**

I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: OKLAHOMA HEART HOSPITAL PHYSICIANS. I understand I am financially responsible for any charges not covered by my insurance.

\_\_\_\_\_  
PATIENT OR AUTHORIZED PERSON

\_\_\_\_\_  
DATE

| Form Revision #        | Form Changes     |
|------------------------|------------------|
| OHHP-F279 (Rev. 6/17)  | NOK & ER Contact |
| OHHP-F279 (Rev. 11/20) | Removed Logo     |

Patient Name: \_\_\_\_\_

Admission Date: \_\_\_\_\_

MRN: \_\_\_\_\_

**CONDITIONS OF ADMISSION**

**Assignment of Insurance Benefits:** I hereby authorize payments from all insurance companies to be made directly to **OKLAHOMA HEART HOSPITAL, LLC** or **OKLAHOMA HEART HOSPITAL SOUTH, LLC**, hereinafter referred to as “**OHH,**” and **OHH PHYSICIANS, LLC**, hereinafter referred to as “**OHHP,**” for benefits otherwise payable to me. I understand that I am financially responsible to the hospital for charges not covered by this assignment. I certify that the above information in support of this claim is true and correct.

**Medical and Surgical Consent:** The patient, or his or her representative, hereby acknowledges the patient’s need for hospitalization or treatment because he or she suffers from a condition requiring diagnosis and medical and/or surgical treatment. The undersigned requests and voluntarily consents to the patient’s receipt of the usual Hospital services, as well as the diagnostic laboratory (such as testing of the blood and other bodily fluids), x-ray procedures, medical and/or surgical treatment, including administration of anesthesia judged to be necessary by the patient’s attending physician, his assistants or other physicians designated by him. The Hospital is authorized to retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience any specimens or tissue removed from the patient’s body during hospitalization or treatment.

**Payment Responsibility:** The undersigned understands that the patient, or another person who specifically agrees to guarantee payment for the patient, is responsible for the payment of all charges of the Hospital or Physician relating to services rendered by the Hospital or Physician to the patient that exceed any third party coverage, including applicable coinsurance payments and deductibles and all amounts for which payment has been denied by any third party. There are other services that will be billed separately from the hospital bill including services performed by other physician specialists who perform services for your care and treatment while a patient at OHH. Amounts due from the patient to the Hospital prior to execution of this Agreement may, at the sole discretion of the Hospital, be consolidated with, and made a part of, the amount due hereunder. The patient shall pay all costs of collection in connection with the enforcement of this commitment, including reasonable attorney’s fees and court costs incurred by the Hospital. You authorize personal contact from us or our third-party collector, via telephone or cell phone numbers provided to us, including line voice, text, auto dialed or prerecorded message.

**Other Uses of PHI:** I understand that in-hospital staff committees may utilize data relating to my condition in the course of studies for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality. I understand that should the recipients use or publish such information or material that my identity shall be confidential and shall not be revealed under any circumstances.

**Provider Based Billing:** When seeing an OHH healthcare provider for any type of outpatient services, you will see a change in the way you are billed. Under “Provider Based” status, OHH is required to bill provider services in two parts. When your medical services are completed, OHHP will submit a claim for the professional fee and OHH will submit a claim for the facility fee. You will receive two statements/bills for your services – one from OHH and one from OHHP.  N/A

(Initial) I acknowledge receipt of the Provider Based Medicare Outpatient Coinsurance Notice; actual liability will depend on services furnished.  N/A

**Notification of HIV Testing:** The undersigned has been notified of the testing of the patient’s blood for human immunodeficiency virus (also known as AIDS) if determined by the patient’s attending physician. This is necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the Hospital or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease.  (Initial)

**Facility Directory:** Unless I object, I understand that my name, location, general condition, and religious affiliations may be released to the clergy or to others who ask for me by name.  Agree  Object (If I object, I understand I cannot receive phone calls, deliveries, etc.)  (Initial)

**Acknowledgment of Notice of Privacy Practices:** I have received/reviewed the “Notice of Privacy Practices” from OHH. If I have any questions, I know to contact the Privacy Officer whose information is provided to me in the “Notice of Privacy Practices”. I understand that if I request a copy of this form one will be provided to me by the Registration staff.  (Initial)

**Disclosure of Physician Interest:** OHH has financial relationships with numerous Oklahoma physicians, some of whom have an ownership interest in the Hospital, and some of whom are paid by the Hospital for services they provide. If the physician who recommended the Hospital to you has a financial interest, and if his or her financial relationship with the Hospital concerns you, you may be treated at an alternative facility, if there is one available. If you would like to discuss your options for treatment at other facilities, or if you have any questions about this disclosure, please ask the person providing you with this form for assistance. A list of physician owners has been provided to me.  (Initial)

**Electronic Messages Consent:** Your health is important to OHH. In order to provide you with the best possible care, OHH, its agents or affiliates may contact you with marketing information, health information, appointment reminders, billing, collections, and other account activities by **telephone, autodialed calls, text, email, robocalls, and artificial, prerecorded voices, and other electronic messages**. It is not possible to guarantee that any transfer of information over text messaging is 100% secure. As a result, OHH cannot guarantee the absolute security of information sent via text message. By permitting OHH to transmit information to you through text messaging, you accept the risk that the transmission is not secure, and that your information may be exposed to a third party. Text message and data rates may apply to messages sent by OHH and multiple texts may be sent each day. I  Agree  Object to receiving text message and other electronic messages sent by OHH or third parties on OHH’s behalf. I understand that I can opt-out of texting at any time by replying STOP to any text message sent by OHH or a third party on behalf of OHH.

**THE UNDERSIGNED CERTIFIES THAT SHE/HE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT’S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient, Patient’s Agent or Representative

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Agent or Representative’s Relationship to patient

| Date & Version #  | Change Summary   |
|-------------------|------------------|
| 08/27/2020 Ver 10 | Multiple Changes |
| 11/20/2020 Ver 11 | Revised Logo     |

## Release of Protected Health Information To Family Members and Persons Involved in Patient's Care

With your permission, OHHP (Oklahoma Heart Hospital Physicians) may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, OHHP may tell a family member when your next medical appointment is scheduled, the results of a laboratory test or procedure or provide the person with a copy of a prescription. Pharmacies will also be notified or sent a list of your medications if required for continuance of care. By completing the top portion of this form, you are authorizing OHHP to release this information to these individuals. However, you are not authorizing OHHP to provide extensive information about your medical history or copies of information from your medical record. If you wish to have this information disclosed, you must complete a separate HIPAA authorization form. Please be aware that OHHP may use its professional judgment in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

| Name | Relationship | Phone Number (Optional) |
|------|--------------|-------------------------|
|      |              |                         |
|      |              |                         |
|      |              |                         |
|      |              |                         |

### Authorization to Leave Voice and Email Messages

OHHP is required to have your permission to leave voice messages or send email messages regarding your Protected Health Information (test results, instruction, etc.) Please check the appropriate boxes:

- Yes, OHHP may leave a message on my answering machine/voice mail regarding my Protected Health Information.
- No, OHHP may not leave a message on my answering machine/voice mail regarding my Protected Health Information.
- 
- Yes, OHHP may email me a message regarding my Protected Health Information.
- No, OHHP may not email me a message regarding my Protected Health Information.

***I understand that if I change my mind about any of the information in this form, I must contact OHHP to revoke this form in its entirety or to complete a new form.***

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Verbally Taken by (OHHP Employee)

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Witness (OHHP Employee)

| Form Revision #        | Form Changes                |
|------------------------|-----------------------------|
| OHHP-F268 (Rev. 1/18)  | Changed Logo                |
| OHHP-F268 (Rev. 11/20) | Removed Logo; Added phone # |