JEFF ALEXANDER, M.D.
Fellow of The American Academy of Dermatology
ASHLEY BIGGS, P.A.-C.
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AUTHORIZATION FOR MEDICAL TREATMENT
Office Practice/Clinic personnel at this facility are hereby authorized to administer any medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

ASSIGNMENT OF INSURANCE BENEFITS
I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. Any payment received may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I agree to pay for any procedures that may be deemed not medically necessary and/or cosmetic by my insurance company. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

PRECERTIFICATION POLICY
I understand that this Office Practice/Clinic will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY
As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this Office Practice/Clinic.

CERTIFICATION
I hereby certify that I have read each of the above statements and have had each item explained to me to my satisfaction. I further certify that I am the patient or am duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.
***PLEASE SIGN HERE**

Patient or Patient's Legal Representative	Relationship to Patient	Date Signed	Witness

Patient Name (Please Print)

DISCLOSURE OF INFORMATION
I understand that my medical records and billing information are made and retained by this Office Practice/Clinic and are accessible to office personnel. Office Practice/Clinic personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. HIPAA Compliance Safeguards are in place to discourage improper access. This Office Practice/Clinic and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, health care provider who is or may become involved with my care. Oklahoma law requires that this Office Practice/Clinic advise you that the information authorized for disclosure may include information which may be considered a communicable of venereal disease, including but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

RELEASE OF PROTECTED HEALTH INFORMATION
Information may be released to the following individual(s)

Name (Please Print)	Relationship	Name (Please Print)	Relationship
Name (Please Print)	Relationship	Name (Please Print)	Relationship

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
A complete description of how your medical information will be used and disclosed by this Office Practice/Clinic is in our NOTICE OF PRIVACY PRACTICES, which you have reviewed.
***PLEASE SIGN HERE**

Patient or Patient's Legal Representative	Relationship to Patient	Date Signed	Witness