Oakwood University Church Health Service.
5500 Adventist Blvd, Ste 103
Huntsville, ,Al 35896
Phone: 256-203-5185

Patient's Name:-————————–

Chart#:_____

Patient Agreement and Acknowledgement

1. ASSIGNMENT OF INSURANCE RESPONSIBILITY: I hereby authorize payment of all insurance benefits, basic and major medical for this period of service made directly to Oakwood University Church Health Service and any provider rendering services. If the check must be made out to me, please send this payment to the address: Oakwood University Church Health Service, P O Box 11878, Huntsville, AL 35814._____**(Initials)**
2. STATEMENT OF FINANCIAL RESPONSIBILITY: I hereby authorize Oakwood University Church Health Service and my provider rendering services to collect for all charges not covered by insurance payments. I also authorize payment for all collection costs, securing, or attempting to collect or secure, including reasonable attorney's fees or Collection Agency Fees, whether suit is necessary or otherwise. I understand that all patients who are considered legal adult are financially responsible for all services rendered._____**(Initials)**
3. AUTHORIZED ACCESS: Patients 14 to 18 years of age who do not wish parents or guardians to have access of their medical records must complete a Restricted Request Form. _____ **(Initials)**

This signature below applies to the items indicated above. I have read and do understand this contract and I have willingly signed this document.

X_____ _____ _____

Signature of Patient and/or Authorized Representative | Date | Witness

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CONSENT FOR MEDICAL TREATMENT: I hereby consent to and authorize Oakwood University Church Health Service to render usual and customary medical treatment, including diagnostic procedures, and other general medical treatment considered advisable or necessary by the Health Care Provider.

The signature below applies to consent for Medical Treatment. I have read and do understand this statement and have willingly signed this document.

X _____ _____ _____

Signature of Patient and/or Authorized Representative | Date | Witness

ACKNOWLEDGEMENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS: I understand and have been offered a Oakwood University Church Health Service'Notice of Privacy Practices that provides a more complete description of information uses and disclosures, that I have the right to review the notice prior to signing this acknowledgment, that Oakwood University Church Health Service reserves the right to change its notices and practices.

X _____ _____

Signature of Patient and/or Authorized Representative | Witness

_____ _____

Date | Title of Witness

I do not agree with all the items in the Patient Agreement and Acknowledgement. I wish to submit my restrictions in writing to Oakwood University Church Health Service, P O 11878, Huntsville, AL 35814.

_____ _____ _____

Signature of Patient and/or Authorized Representative | Date | Witness

SIGNATURE NOT OBTAINED *Section to be completed if the Partent refuses to sign and acknowledge this form.*

First Attempt: Date Time: AM/PM Reason: (check one) • Emergency • Communication Barrier • Patient Refusal

Detailed Reason for Refusal ————————————————————————