Norman Regional
HEALTH SYSTEM

NORMAN REGIONAL
NORMAN REGIONAL MOORE
NORMAN REGIONAL HEALTHPLEX

AUTHORIZATION TO VERBALLY DISCUSS/DISCLOSE OUTPATIENT PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ______________________

Social Security Number: ______________________

I hereby authorize Norman Regional Health System (NRHS) staff and physicians to verbally discuss/disclose information about my condition, care and treatment during my current visit at Norman Regional Health System to the following:

______________________________________ ______________________________________
Person to Whom Disclosure is Authorized Relationship to Patient

I understand this individual will be asked to state my birth date to verify they are the person listed above.

Information is being released for the following purpose: continued contact with family and friends during my treatment

Date, Event, or Condition when Consent Expires: Upon Discharge from Oklahoma Wound Center (NRHS)

*I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release.

*I understand this authorization is for verbal communications only, and that I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I further understand I will need to provide an additional signed authorization before any written disclosures are made (copies of my medical record), and that I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. **Unless revoked or otherwise indicated, this authorization will expire upon my discharge from Oklahoma Wound Center (NRHS).**

*I release Norman Regional Health System, its agents and employees, from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.

*Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

*I understand I have the right to restrict discussion of my protected health information.

______________________________________ ________________ ________________
Signature of Patient or Legal Guardian Date Time

____
Description of Legal Representative's Authority

Patient Label

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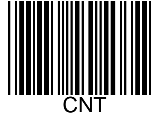

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OKLAHOMA WOUND CARE CENTER

AUTHORITY TO PHOTOGRAPH FOR MEDICAL RECORD DOCUMENTATION

Name: ____

Address: ____

City: ___________________________ State: __________ Zip: _____________________

I hereby authorize identification photograph(s) and photograph(s) of my wounds for my patient medical record documentation:

_____________________________ by____
(Patient Name) (Oklahoma Wound Center staff member)

And hereby release Norman Regional Health System, in Norman, Oklahoma, from any and all responsibility attached thereto.

Date: __________________________ Time: ___________________

Signature: ____

Relationship: ____

Witness: ____

Patient Label

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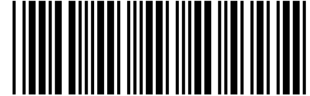

WCPTB

OKLAHOMA WOUND CENTER – PATIENT BILLING INFORMATION

The Oklahoma Wound Center (OWC) is a Norman Regional Health System outpatient clinic comprised of physicians and nurses who specialize in wound care. The physician and the hospital will charge separately for services rendered during clinic visits.

Wound care visit charges may include at least one of the following:

*Clinic Visit	*Procedure Charge (i.e. wound debridement)
*Laboratory Tests	*Hyperbaric Oxygen Therapy
*Radiology (i.e. X–Rays)	*Other Services that may be performed in the hospital

The Oklahoma Wound Center staff is always available to answer any questions you may have about the billing process.

THE HOSPITAL

The hospital bill contains charges for the use of the OWC staff, exam room, equipment, supplies, etc. Also, included within the hospital charges will be laboratory charges, radiology (x–rays) charges and any other additional services that may have been provided during that billing period. The above charges may or may not appear on separate bills.

THE PHYSICIAN

Each physician you see at the OWC will bill separately for their services. This bill will typically come from the physician's billing office. The physician charges include the services provided by that physician for that billing period.

The OWC physicians and the insurance companies are familiar with the services and specific charge codes for wound care. Even though the service description and/or service dates may appear the same on the physician bill and the hospital bill, ***you are not being billed twice for the same service***. The insurance companies know what portion of the service is physician related and what portion of the service are hospital related.

IF YOUR PRIMARY INSURANCE IS MEDICARE OR MEDICAID

The hospital will bill Medicare/Medicaid directly for services rendered at the OWC. Medicare/Medicaid will then notify you when they have paid their portion of your hospital bill. Should you have a secondary insurance; the hospital will also send a bill to them for their portion of the services rendered. You may also receive notification from the secondary insurance company regarding what they have paid to the hospital. ***You will be responsible for any outstanding balances*** after payments are received by your primary and/or secondary insurance.

IF YOUR PRIMARY INSURANCE IS AN INDIVIDUAL / GROUP PPO OR HMO

The hospital will bill your insurance company. Verification of your insurance helps us identify your appropriate deductible and co–payment amounts; however, you will be responsible for payment of any deductible or co–payment amounts at the time of service.

IF YOU DO NOT HAVE INSURANCE COVERAGE

The hospital may require payment (either in full or partial) at the time of the visit. If you are unable to pay, the OWC can refer you to the hospital Business Office to determine if you qualify for some type of assistance or will allow you to set up a payment plan.

IF YOU HAVE QUESTIONS REGARDING YOUR BILLS / STATEMENTS

The hospital Business Office is available Monday – Friday between 9:00am and 4:30pm for any questions regarding your hospital bill. For any questions relating to the physician's charges, please contact that physician's billing office directly.

Patient Signature: ______________________________ Time: __________ Date: ____________

Witness Signature: ______________________________ Time: __________ Date: ____________

Patient Label