

MEDICAL TREATMENT AUTHORIZATION

I agree to procedures that are requested by me and/or ordered by my physician(s) in connection with my inpatient, outpatient and/or emergency treatment, and medications. If I am a pregnant patient delivering, I consent to hospital care of my infant(s) and consent for release of my private health information needed to care for my infant. You have the right to accept or refuse any care, treatment or service your physician or staff recommends to you. You should ask for information about anything you do not understand or if you need more information.

I acknowledge that I have received written notice of my patient rights, including my right to execute an Advance Directive in accordance with Oklahoma State Law.

☐ Yes ☐ No I have a legal representative.
☐ Yes ☐ No I want to appoint a patient representative to make decisions for me should I become unable to make healthcare decisions. If yes, the following person should make decisions for me: _____ and their contact information is: _____

I understand I have a right to receive information in a manner or language I, and/or my Representative, can understand. I understand interpreter services are available 24 hours a day at no cost.

If my treatment includes treatment groups, I understand that my participation in these groups or classes may involve discussions of my condition in the presence of other patients and I consent to the discussion.

I understand that my medical records will be maintained in the Epic Electronic Health Records ("EHR") system. I understand and agree that my information may be accessed by another facility or provider who participates in our EHR system for purposes of my treatment, as well as for purposes of system operations and management, and evaluating and improving patient care.

I understand that the practice of health care delivery may involve "telemedicine" which is the transfer of my medical data, or exchange of medical information by means of audio, video or data communication to a medical care provider with expertise in a particular area of care. A healthcare provider may be able to assist in the examination and provide additional information about a diagnosis. The physician and staff who have access to your medical information will keep it confidential in accordance with laws and confidentiality policies.

TELEPHONE CONSUMER PROTECTION ACT CONSENT DISCLOSURE

Consent to Email, Telephone Calls and Text Messages for Appointment Reminders, Healthcare Information, Discharge Instructions, Account and Billing Communications, and Other Communications.

By providing my telephone number (whether landline or wireless) and/or email address to Utica Park Clinic, I expressly consent that Utica Park Clinic and its employees and agents may contact me by telephone, short message services (SMS), or text at any telephone number (whether landline or wireless) I have provided to Utica Park Clinic or, at any number forwarded or transferred from that number regarding any matter that is related to my treatment, my account, and/or Utica Park Clinic's services, including, but not limited to the following:

my hospitalization or treatment, my condition and plan of care, the services rendered, patient surveys, discharge instructions, communication made to me or related to my account, or my related financial obligations including, but not limited to, payment reminders, delinquent notifications, instructions and links to patient billing information, and other healthcare communications including, but not limited to, notification and reminders of appointments, notification and reminders that certain medications are ready for pick-up, information about programs or services that might be of interest to me, information about insurance coverage/eligibility, information about referrals, and information about available treatment options and capabilities

These communications may be transmitted by or on behalf of Utica Park Clinic and its employees and agents using pre-recorded/automated voice messages, use of an automatic dialing device, or other technologies. I understand that providing my prior express written consent to receive such communications is not a condition of receiving services or care from Utica Park Clinic. I understand that I will be able to change my preference at any time. This can be done via your MyChart account under Your Menu, then Accounting Settings, then Personal Information, or by contacting patient access/registration or your physician's office.

FINANCIAL RESPONSIBILITY

I hereby assign to Utica Park Clinic ("UPC") and any health care provider designated by UPC to receive such monies, and all rights and interest in insurance benefits and/or entitlements and I direct that all such payments be made directly to UPC or its designee. Charges for services shall be at the provider's regular rates unless otherwise agreed in writing by UPC or as required by law.

I understand I am financially responsible for deductibles, coinsurance, and all services not covered by insurance benefits and/or entitlements. I understand that if UPC or any of its affiliates are out-of-network with my insurance plan, then my financial responsibility may include: (1) higher coinsurance and deductible amounts; and (2) UPC's full charges, including the amount that exceeds the allowable charges of an in-network preferred provider.

A safe is available for safekeeping of valuables. UPC and its affiliates are released from responsibility for all valuables or personal items, including eyeglasses, dentures, and hearing aid(s) and jewelry that I retain in my possession during my hospital stay or outpatient visit.

☐ Patient ☐ Guardian ☐ Parent of Minor ☐ Power of Attorney

Witness

Date / Time

If not signed, complete the following to explain the reason why:

☐ Emergency situation ☐ Individual refused to sign
☐ Unable to sign
☐ Other: _____

INFORMATION ABOUT YOUR SPECIFIC RIGHTS ABOUT ADVANCE DIRECTIVES

The Patient Self Determination Act directs UPC to inform you that you have rights under Oklahoma State Laws to make decisions about your care. You have the right to accept or refuse any procedure or care that your physician or staff recommends to you. Your physician will prescribe a treatment plan for you and talk with you about those recommendations including the risks, benefits and alternatives. You should ask for information about anything you do not understand or if you need more information. If at any time you feel your rights are not being respected, your nurse will help you contact the facility representative.

The Oklahoma Rights of the Terminally Ill and Persistently Unconscious Act (Living Will/Appointment of a Healthcare Proxy Law) is a way for a person with decision making capacity to specify future circumstances and conditions in which life sustaining treatment should be withheld. You can appoint another person (aka: surrogate decision maker) to make those decisions for you should you become unable to make decisions for yourself. You can do both. A Living Will does not address your wishes or belongings after death. It is only for certain types of healthcare decisions. A Living Will may apply only to future events or circumstances when the person becomes terminally ill, not necessarily the present. The Oklahoma Do Not Resuscitate Act provides a specific written form called a DNR form that you should sign **only** if you are certain that under no circumstances is cardiopulmonary resuscitation to be provided. A copy of each of these types of Advance Directives can be made available to you and our staff may assist you if you elect to complete an advance directive. If you are scheduled for surgery, you will want to talk with your surgeon and your anesthesiologist about your advance directive prior to surgery. We will not recognize DNR during anesthesia. If considering such documents raises difficult issues for you, our Pastoral Care Department, if applicable, or others are available for more intensive help, please see the front desk or registrar for additional information. You may also have a Durable Power of Attorney for Healthcare. UPC recommends that all individuals appoint a healthcare Proxy to assure that someone the individual knows/trusts is authorized to make decisions for them if they become incapacitated.

A psychiatric advance directive is akin to a traditional advance directive for healthcare. An individual who is concerned that at some point he/she may be subject to involuntary psychiatric commitment or treatment has the right to execute a psychiatric advance directive. The psychiatric advance directive names another person who is authorized to make decisions for the individual if he/she is determined to be legally incompetent to make his/her own choices. It may include instructions about hospitalization or treatment, alternatives to hospitalization or treatment, the use of medications, types of therapies and the patient's wishes concerning restraint or seclusion. It includes information as to who to notify upon admission, as well as who should not be permitted to visit.

You should keep your advance directive at home with you in a safe place. You should provide a copy to your primary care physician for your medical record in their office. Tell your family where your advance directive is. We recommend that you talk with them about it. **Do not put your advance directive in a safe deposit box with other important papers.** Your family and healthcare providers need access to it readily when you are unable to make decisions for yourself. We will put a copy in your medical record for this hospitalization or treatment.

If you have an advance directive and did not bring it with you, it is urgent that you make arrangements to bring it. In the meantime, our best advice is to complete a document approved by the State of Oklahoma today. Our staff can help you update your current advance directive, or complete a new one. Please tell your doctor and/or nurse about the substance of your advance directive so we can document what you tell us in your medical record. We want to honor your values and wishes about healthcare that you believe is right for you.

COMPLAINTS AND GRIEVANCES

You and/or your representative have the right to express complaints or grievances related to the quality of care received, to have those complaints heard and when possible, resolved. Complaints/grievances should be directed initially to and reviewed by the department and clinical manager and/or director providing the patient care which is the subject of the complaint. If the problem cannot be resolved quickly, it may become a formal grievance handled through the process defined for the facility.

Patients have the right to address their concerns to UPC Risk Management, 1145 S. Utica Ave, #110 Tulsa, OK 74104, 918-579-2981.

Oklahoma State Dept of Health
 1000 NE 10th Street
 Oklahoma City, OK 73117-1299
www.ok.gov/health
 405-271-6576

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