Skiatook Family Clinic

A Federally Certified Rural Health Clinic
201 East Second Street • Skiatook, OK 74070
Phone: (918) 396-1262 | Fax: (918) 238-6577

General Consent to Treat Agreement

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Sex: [ ] M [ ] F [ ] Other

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

CONSENT TO TREAT

I, _____ (patient or patient's legal representative), hereby give my consent for the health care providers at Skiatook Family Clinic, a federally certified Rural Health Clinic, to provide medical evaluation, diagnosis, and treatment for the above-named patient. I understand that this consent covers all services deemed necessary by the health care providers, including but not limited to:

- Medical examinations and evaluations
- Diagnostic and laboratory tests
- Imaging studies (X-rays, etc.)
- Medications and immunizations
- Medical treatments or procedures
- Referrals to specialists when clinically indicated

CONSENT FOR CARE BY MID-LEVEL PROVIDERS

I understand that Skiatook Family Clinic is a Rural Health Clinic and that my care may be provided by physician assistants (PAs) and nurse practitioners (NPs) working under the supervision of a licensed physician, as permitted by Oklahoma state law and federal Rural Health Clinic regulations. I consent to receive care from these qualified mid-level providers.

AI-ASSISTED DOCUMENTATION

I understand that Skiatook Family Clinic may use artificial intelligence tools to assist with clinical documentation during my visit. These tools help providers meet administrative and insurance documentation requirements more efficiently, allowing them to focus on my care. All information processed by these tools remains protected under HIPAA, and my provider always reviews and approves the final documentation.

I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me regarding the results of the medical evaluation, diagnosis, or treatment. I acknowledge that I have the right to refuse or withdraw my consent for any medical evaluation, diagnosis, or treatment at any time, and that doing so may have consequences for my health.

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General Consent to Treat Agreement (continued)

PRIVACY AND CONFIDENTIALITY

I understand that Skiatook Family Clinic will maintain the confidentiality of my health information according to the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state laws and regulations. I acknowledge that I have been offered a copy of the clinic's Notice of Privacy Practices.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Skiatook Family Clinic to release any necessary medical information to my insurance company, Medicare, Medicaid, or other third-party payers for the purpose of processing payment for services rendered. This authorization includes the release of information related to substance abuse treatment, mental health treatment, and HIV/AIDS status to the extent permitted by law and necessary for payment.

FINANCIAL AGREEMENT

I understand that I am financially responsible for any charges not covered by my insurance, including co-payments, deductibles, and any amounts due at the time services are rendered. I agree to pay all such amounts in a timely manner. I understand that Skiatook Family Clinic participates in Medicare and Medicaid programs and follows all applicable billing requirements for Rural Health Clinics.

ASSIGNMENT OF BENEFITS

I hereby assign to Skiatook Family Clinic all medical benefits payable under my health insurance plan, Medicare, Medicaid, or any other third-party payer. I authorize payment directly to Skiatook Family Clinic for services rendered.

By signing below, I acknowledge that I have read and understand this Consent to Treat Agreement, and I agree to its terms and conditions. I have had the opportunity to ask questions and have received satisfactory answers.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name: _____

Relationship to Patient (if signed by representative): _____

FOR HEALTH CENTER USE ONLY

Witnessed by: _____ Date: _____

Staff Name (Print): _____ Title: _____

Notes (if patient unable to sign, document reason):

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