ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

CONSENT FOR ROUTINE MEDICAL TREATMENT

Melissa Morgan M.D., P.C., and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by Melissa Morgan M.D., P.C., and are accessible to its personnel and medical staff for use in my care. Melissa Morgan M.D., P.C., personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Melissa Morgan, M.D., P.C., is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Melissa Morgan M.D., P.C.,'s charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the **information authorized for disclosure may include information which may be considered a communicable or 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. You may revoke this consent in writing addressed to Melissa Morgan, M.D., P.C., except to the extent we have already acted in reliance on it.**

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for Melissa Morgan M.D., P.C., charges payable to the insured are to be made payable to Melissa Morgan. M.D., P.C., and that insurance benefits for services provided by physicians in the practice setting otherwise payable to the insured are to be made payable to the physicians(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bills for which you are liable, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

You understand that Melissa Morgan, M.D., P.C., will assist with insurance precertification requirements which are the responsibility of the policyholder and/or practice, 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 to you, payment is guaranteed for any amount due for such services provided by Melissa Morgan, M.D. P.C.,. Charges for services and goods shall be at Melissa Morgan M.D., P.C.,'s billed charges rates unless otherwise agreed to in writing by Melissa Morgan, M.D., P.C. **Failure to cancel your clinic appointment within 24 hours or multiple cancellations may result in a $50.00 fee. The fee for cosmetic or surgical appointment cancellations is $85**_____(initials) X

PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect has an original.

X _____

Signature of Patient or Patient's Legally Authorized Representative **(Documentation Must Be Provided)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Melissa M. Morgan, M.D, P.C., is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgment.
The Notice is posted throughout our office and you will be given a copy for your personal use upon request.

I have received a copy for review of Melissa Morgan, M.D., P.C.'s Notice of Privacy Practices dated: April 14,2003

X _____ _____ X _____

Patient or Representative | Legal Authority of Representative | Date signed

Basis of refusal, if refused: _____

Authorization to disclose Pathology or lab results to: _____

X Name | Relationship