St. John Clinic

Occupational Health

□ Bartlesville-3550 SE Frank Philips Blvd □ Bixby-7333 E 121 St. South
□ Claremore-1910 South Falcon Avenue □ Jenks-220 South Elm
□ Sand Springs-Morrow Road and Hwy, 97 □ Tulsa-8131 S. Memorial Drive, Suite 102
□ Tulsa-1717-A South Utica

PATIENT INFORMATION AND AUTHORIZATION TO TREAT

PATIENT INFORMATION				Today's **Date:**
PATIENT'S LAST NAME:	FIRST:	M.I.	□ Female □ Male	
ADDRESS:	CITY:	STATE:	ZIP CODE:	
HOME PHONE#	CELL PHONE#	SOCIAL SECURITY#	DATE OF BIRTH	AGE

EMPLOYER INFORMATION (read and <u>**complete**</u> this section with the **employer** <u>**responsible for payment of services**</u>.)

We must get authorization to treat from **your primary employer**. If you are a contracted employee or work for a temporary personnel or staffing service complete section below with your primary employers information. **Do Not write the information for the company to whom you are temporarily assigned**.

EMPLOYER:	SUPERVISOR:	SUPERVISORS PHONE#	
EMPLOYERS ADDRESS:	CITY:	STATE:	ZIP CODE:
EMERGENCY CONTACT NAME & RELATIONSHIP:		**PHONE#**	

INJURY INFORMATION: DID YOUR PRESENT INJURY OR PROBLEM OCCUR AT WORK? □Yes □No □Unsure	If Yes, Specifically when did the injury occur? Date: __________ Time: __________ □ Unsure
Describe your usual job duties, tasks or function:	
Describe in detail how specific incident/event occurred:	
State **specific problem** (Chief complain/symptoms):	
Any previous injuries or problems related to this body part? □Yes □No	Any past work related or claimed injuries □Yes □No
Any previous evaluation or treatment for this or similar problem? □Yes □No	Was any personal protective equipment (PPE) being used at time of injury? □Yes □No

AUTHORIZATION AND AGREEMENT FOR TREATMENT

1. CONSENT FOR TREATMENT. I understand that medical treatment of an urgent nature is necessary for myself or the patient, and that such medical care, treatment, and procedures will be performed by independent physicians, physician assistants, nurse practitioner and by other employees of St. John. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results which may be obtained.
2. **RELEASE OF MEDICAL INFORMATION:** I hereby authorize St. John Clinic to release any medical information in connection to today's services to my employer (as well as pre-employment visits) ____, its representatives, and/or its agents assisting in the processing of workers compensation claims.-*OK§85A & HIPAA OCR 45CFR 164.502;164.512;164.522*
3. This <u>Authorization is</u> <u>**Valid for one year**</u> unless you specify otherwise (enter expiration date) ______________________________.
4. I understand this may include records involving psychiatric, drug abuse and/or alcohol abuse treatment records. The information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.
5. AGREEMENT TO PAY FOR SERVICES: In the case the illness/injury is not covered by my employer, for consideration and treatment provided to the patient, I agree to pay all charges for services rendered to myself or the patient.
6. If you are the legally recognized representative of the patient you must provide supporting documentation. You may revoke this Authorization at any time by providing a written statement, except to the extent that St. John Clinic has already completed action on it. You are entitled to a copy of this authorization. The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem. The information released pursuant to this Authorization may be re-disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. St. John Clinic will not condition treatment or payment of the provision of this Authorization. HIPAA *OCR 45 CFR 164.508*
7. I realize this examination is not an in-depth or comprehensive exam and is intended solely for the specific purpose of a preplacement or injury examination. It is not intended to take the place of a routine or preventative examination by my private physician.

I CERTIFY TO THE ACCURACY OF THE INFORMATION ENTERED ON THIS FORM AND HAVE READ THIS "AUTHORIZATION AND AGREEMENT FOR TREATMENT" INFORMATION ABOVE.

SIGNATURE OF PATIENT OR GUARDIAN:	RELATIONSHIP TO PATIENT:	DATE: