Oregon Specialty Group

Patient Signature Page

Notice of Privacy Practices: Acknowledgment of Receipt

We are required by law to offer you a copy of our privacy notice. This notice tells you how your health information may be used and shared. You can view the notice online through our website at oregonsg.com or you can request a printed copy at the reception desk of any of our clinics.

By signing below, I acknowledge that I have received a copy or have been offered a copy of the Notice of Privacy Practices of Oregon Specialty Group (which includes Oregon Oncology Specialists, Oregon Rheumatology Specialists, Oregon Infectious Disease Specialists and Oregon Specialty Infusion).
I understand that if I have any questions, I can contact the Privacy Officer listed on the copy of the Privacy Notice. I understand that I can find a copy of the Privacy Notice on our website or ask for a copy at any time. The below undersigned is the patient or the patient's authorized representative.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

For Office Use only: We attempted to obtain written acknowledgment of receipt, but it could not be obtained because:

☐Individual unable or refused to sign

☐Other (Please specify): _____

Agreement for Services and Practice Policies

Medical Services: I consent to receive medical services at Oregon Specialty Group. I understand that these services may include examinations, diagnostics and treatments deemed necessary by the healthcare provider.

Appointment Reminders and Portal Enrollment: I understand and consent to support services such as appointment reminders and portal enrollment and will notify the practice if I would like to withdraw from these services.

Telehealth and Digital Communication: I hereby give my informed consent for the use of telemedicine in my medical care, and I agree to reside in the state of Oregon during rendered services. I hereby authorize Oregon Specialty Group and its affiliates to use telemedicine during my diagnosis and treatment and will notify the practice if I would like to withdraw from these services.

By signing below, I acknowledge that I have read and understand the above policies.

Signature: _____ Date: _____

If authorized signer, printed name and relationship to the patient: _____