Central Ohio Primary Care Physicians, Inc. - Ohio Center for Pediatrics

Date:

GUARANTOR *(CIRCLE ONE)****: MOTHER FATHER GUARDIAN OTHER*** _____
(Person responsible for payment)

Name _____, _____, _____
LAST FIRST MIDDLE

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Cell) _____ (Work) _____

SSN_____ DOB _____

Employer _____ Occupation _____

OTHER ADULT *(CIRCLE ONE)****: MOTHER FATHER GUARDIAN OTHER*** _____
(Person responsible for payment)

Name _____, _____, _____
LAST FIRST MIDDLE

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Cell) _____ (Work) _____

SSN_____ DOB _____

Employer _____ Occupation _____

CHILDREN

First_____ MI_____ Last Name _____ DOB _____ M/F

First_____ MI_____ Last Name _____ DOB _____ M/F

First_____ MI_____ Last Name _____ DOB _____ M/F

First_____ MI_____ Last Name _____ DOB _____ M/F

COMMUNICATION PREFERENCES

To assist in your child(ren)'s care, it may be a necessary to release their Protected Health Information to someone other than yourself. To whom may we talk?

Other Person _____ Relationship _____ Phone Number _____
(PLEASE PRINT)

Other Person _____ Relationship _____ Phone Number _____
(PLEASE PRINT)

May we leave a message on:
Your answering machine/voicemail at home YES ☐ NO ☐ Your voicemail at work YES ☐ NO ☐

I understand COPC will notify me if COPC is unable to comply with my request. I also understand that my child's protected health information may be released as my physician determines appropriate in an emergency situation. I have been offered the office Notice of Privacy Practices for COPC. Yes _____ No _____

Signature of patient/ legal guardian: _____ Date: _____
(if over the age of 18/ if inder the age of 18)

(Please Print)
Name of person signing: _____ Relationship _____

Patient Responsibilities

I understand it is my responsibility to verify with my insurance company if any and all services are covered and/or require pre-authorization. I understand that if I have a copay, it is payable at the time of service. I hereby authorize my insurance carrier to issue payment directly to Central Ohio Primary Care, Inc. all covered services that my child(ren) receive. If I do not have insurance coverage for my child(ren), I understand that payment is due at the time of service. I understand that if inaccurate information is given to Central Ohio Primary Care, Inc.and the information is not corrected until after my insurance company's timely filing limit, I will be responsible for the bill.

Signature (Relationship) _____ **Date** _____