



RIVERSIDE MEDICAL GROUP

INSURANCE PAYMENT CONSENT

- I understand that my insurance carrier can choose to assign benefits to Central Ohio Primary Care Physicians or my insurance carrier may make payment directly to me.
- I understand and certify that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier, as well as for any applicable co-payment, co-insurance, deductible, or charges for non-covered services provided to me or to any of my dependents.
- I am also responsible for providing up to date accurate insurance information.

By signing below, I certify that I will pay to Central Ohio Primary Care Physicians, any co-payments, co-insurance, deductibles, or non-covered services. I will immediately pay to Central Ohio Primary Care Physicians any payments that I receive from my insurance company for services provided to me or my dependents. I will also be responsible for any amounts not paid by insurance because I have not provided the appropriate insurance information for billing.

HIPPA

I have been offered the NOTICE OF PRIVACY PRACTICES FOR COPC

Name (Please Print) _____

Signature _____

Date _____