CENTRAL OHIO
PRIMARY CARE

McConnell Family Practice

Insurance Payment Consent

I understand that my insurance carrier can choose to assign benefits to Central Ohio Primary Care Physicians, Inc 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 service 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-payment, co-insurance, deductibles, or charges for non covered services. I will immediately pay to Central Ohio Primary Care Physicians any payment 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.

Name (please print)________________________________ Date _______________________

Signature _____________________________________ Witness _____________________

I have been offered the **NOTICE OF PRIVACY PRACTICES** for COPC.

Signature _____________________________________ Date ________________________