



**CENTRAL OHIO
PRIMARY CARE**

PATIENT INFORMATION Please print & complete the form and bring it to your appointment.				TODAY'S DATE	
Name	DOB:	Age:	Sex: M F	SS#	
Address:		Phone <i>primary</i> : ()		Phone <i>alternate</i> : ()	
City:	State:	Zip:		Cell # ()	
Employer:	Employer Address:			City:	State: Ph: ()
Marital Status: S M D W		Spouse Name:		Spouse DOB:	Spouse SS #
Spouse Address if different		City:	State:	Zip:	Spouse Ph. ()

NEAREST RELATIVE (EMERGENCY CONTACT) OTHER THAN SPOUSE:

Name	Relationship:	Ph:			
Address:	City:	State:	Zip:		

Personal consent for care and treatment:

I authorize Dublin Internal Medicine and/or Central Ohio Primary Care Physicians to provide care and treatment under my physician's direction.

Patient Signature & Date

Witness (office staff) & Date

ALTERNATE CONSENT:

I hereby authorize Dublin Internal Medicine and/or Central Ohio Primary Care Physicians to provide care and treatment for _____, who is unable to give consent because he/she is a minor, is unable to comprehend, or is other wise unable to personally give consent at the time of treatment.

Relationship to patient Date alternate signature Witness (office staff)

INSURANCE INFORMATION:

In order for Central Ohio Primary Care Physicians to submit an accurate claim to your insurance company, please be prepared to present your insurance card (s) at each and every visit.

By signing below I acknowledge that I have been offered a copy of the privacy practices for COPC/Dublin Internal Medicine. Name: _____ Date: _____

I am aware that appointments not cancelled with 24 hours notice will result in a \$25.00 fee that will not be billed to insurance. Signed _____

Please present your insurance cards at every appointment. To submit a claim to your insurance company, we will need complete and accurate insurance information. Thank you.

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

All other Insurance companies and/or third party payers: I hereby authorize Central Ohio Primary Care Physicians, Inc. and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries to issue payment directly to Center Ohio Primary Care Physicians, Inc. and or physicians(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Medicare and Medicaid: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release it to the Social Security Administration, Medicare, Medicaid or its intermediaries or carriers any and all information for this or related Medicare of Medicaid claim. I authorize and request that payment be made directly to Central Ohio Primary Care Physicians, Inc. **Guarantee of Payment:** I UNDERSTAND that filing a claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Central Ohio Primary Care Physicians, Inc to me or the patient as indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed for Worker's Compensation and/or claims due to personal injury, accidents or illnesses.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

PATIENT SIGNATURE: _____ **DATE:** _____

(If patient is 18 years or older, his/her signature is required, in addition to the "responsible party".

RESPONSIBLE PARTY: _____ **DATE:** _____

(if other than patient)



Office Use Only: P#: _____

Dr. #: _____

ADULT REQUEST FOR CONFIDENTIAL COMMUNICATION

I hereby request to receive confidential communications from the practice in the following manner:

(Please Print)

Patient Name: _____ Middle Initial: _____ DOB: _____

Primary Physician: _____ **(Please Print)**

You may communicate my protected health information with the following:

(Please Print)

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

You may leave limited protected health information on a voicemail or answering machine of the names listed above (lab or test results, information about scheduling or prep for a test or procedure or information regarding follow up with a specialist)

Yes _____ No _____

Address where I would like my protected health information mailed to:

Street _____ Apt _____

City _____ State _____ Zip _____

Phone: _____

You may leave messages on voicemail or Answering Machine **Yes** _____ **No** _____

I understand COPC will notify me if COPC is unable to comply with my request. I also understand that my 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 under the age of 18)

(Please Print)

Name of person signing: _____ Relationship: _____

Office Use Only

Date received: _____ Entered into Mysis: _____ Entered into IC: _____

Initials: _____