CENTRAL OHIO PRIMARY CARE

Office Use Only:
Child Account #: _____
Provider: _____

All starred(*) items must be completed. Thank you!!

Guarantor Information *(Individual responsible for bills and payment.)* *Today's Date:* ____/____/_____

Last Name*: _____ First Name*: _____ Middle Initial: _____

Relationship: _____ Home or Cell #: (_____) _____-_____ Work #*: (_____) _____-_____ x-_____

Birthdate*: ____/____/_____ SSN*: _____-____-_____ Gender: ☐ Male ☐ Female

E-mail Address*: _____ ☐ None **Office Use :** Acct #: _____

Mailing Address*: _____ City*: _____ State*: ____ Zip*: _____-_____

If different from Mailing Address:

Street Address : _____ City: _____ State: ____ Zip: _____-_____

Employer: _____ Main #: (_____) _____-_____

Employer Address: _____ City: _____ State: _____ Zip: _____

☐ Individual is Emergency Contact ☐ Individual is primary care giver

*May we release Protected Health Information to this individual ☐ Yes ☐ No _____Initial

Legal Guardian *(Required)* ☐ Same as Guarantor ☐ Mother ☐ Father ☐ Other _____ ☐ Person is Emergency Contact

Last Name*: _____ First Name*: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home or Cell #*: (_____) _____-_____ Work #: (_____) _____-_____ Ext.: _____ SSN*: _____-____-_____

E-mail Address: _____ ☐ None Birthdate*: ____/____/_____

*May we release Protected Health Information to this individual ☐ Yes ☐ No _____Initial ☐ Individual is primary care giver

Additional Contact *(Optional)* ☐ Individual is Emergency Contact ☐ Individual is primary care giver

Last Name*: _____ First Name*: _____ Relation*: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone*: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext.: _____ SSN: _____-____-_____

*May we release Protected Health Information to this individual ☐ Yes ☐ No _____Initial Birthdate: ____/____/_____

Child Information Last Name*: _____ First Name*: _____ Middle Initial: _____

Child resides with: ☐ Guarantor ☐ Legal Guardian ☐ Contact ☐ Other as follows:

Address: _____ City: _____ State: ____ Zip: _____-_____ Home #*: (____) ____-_____

Birthdate*: ____/____/_____ Gender*: ☐ Male ☐ Female ☐ Unknown SSN*: _____-____-_____

Ethnicity*: ☐ Hispanic/Latin ☐ Refuse to Report ☐ Non Hispanic/Latin

Race*: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Other ☐ Native Hawaiian/Other Pacific Islander ☐ Refuse to Report

Preferred Language*: _____

Vision Impaired*: ☐ Yes ☐ No Hearing Impaired*: ☐ Yes ☐ No

Insurance Information *Self Pay (No Insurance)* ☐

Primary Insurance: _____ Phone: (_____) _____-_____ Policy#: _____

Subscriber*: _____ Relation*: _____ Gender*: ☐ Male ☐ Female Birthdate*: ____/____/_____

Secondary Insurance: _____ Phone: (_____) _____-_____ Policy#: _____

Subscriber*: _____ Relation*: _____ Gender*: ☐ Male ☐ Female Birthdate*: ____/____/_____

Place any additional insurances on a separate piece of paper. Also, please present all current health insurance cards to the Front Desk. Thank you!

Please continue on the back side of this form. Thank you!

CENTRAL OHIO PRIMARY CARE

Office Use Only:

Child Account #: _____

Confidential Communications

I hereby request to receive confidential communications for my child from COPCP in the following manner:

Telecommunications/E-mail:

Please leave messages as follows (check all that apply):

☐ Home Phone of Record ☐ Brief ☐ Detailed ____Initial ☐ Cell Phone of Record ☐ Brief ☐ Detailed ____Initial

☐ Work Phone of Record ☐ Brief ☐ Detailed ____Initial ☐ E-Mail of Record ☐ Brief ☐ Detailed ____Initial

Postal Communications:

Please mail my child's protected health information to me at (Select only one):

☐ Guarantor's Mailing Address of Record ____Initial ☐ Guarantor's Street Address of Record ____Initial ☐ Other as follows ____Initial

Address: _____ City: _____ State: ____ Zip: _____

Individuals *(People we may leave messages with)*:

1) Last*: _____ First*: _____ Relation*: _____ Phone: (_____) _____-_____

☐ COPCP may leave brief protected health information via voice message for this individual ____Initial

2) Last*: _____ First*: _____ Relation*: _____ Phone: (_____) _____-_____

☐ COPCP may leave brief protected health information via voice message for this individual ____Initial

3) Last*: _____ First*: _____ Relation*: _____ Phone: (_____) _____-_____

☐ COPCP may leave brief protected health information via voice message for this individual ____Initial

I understand COPCP will notify me if COPCP 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 received the Notice of Privacy Practices at Central Ohio Primary Care Physicians, Inc. ☐ Yes ☐ No ____Initial

Insurance Assignment and Acknowledgement:

I understand my child's insurance carrier can choose to assign benefits to Central Ohio Primary Care Physicians, Inc. or the insurance carrier may make payment directly to the subscriber. I understand and certify the account guarantor is financially responsible for all health care service charges that are paid to the subscriber directly by my child's insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependants. I am also responsible for providing up-to-date and accurate insurance information.

***Medicare and Medicaid**: I certify 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 to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment.

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

Guarantor or Guardian Printed Name	*Guarantor or Guardian Signature*	*Date Signed*

Prescription History Consent

By signing below, I authorize Central Ohio Primary Care Physicians, Inc to request and use any and all available prescription history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I am aware Central Ohio Primary Care Physicians, Inc. uses a secured electronic connection to send and receive most prescriptions within the office.

Guarantor or Guardian Printed Name	*Guarantor or Guardian Signature*	*Date Signed*