COLUMBUS INTEGRATIVE
Family Medicine Center

CONSENT TO TREATMENT, AUTHORIZATION TO RELEASE INFORMATION, STATEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I authorize the facility and physician(s) to provide diagnostic and treatment services to me.

The facility and physician(s) have my permission to release any information needed for completion of their claims for payment from third-party payors including, but not limited to: insurance companies, health maintenance organizations, preferred provider organizations, government agencies and their representative.

I permit release of information concerning dates of treatment, condition, diagnosis, procedures or surgeries to my personal physician, referring physician and/or the referring facility or for follow-up care. I am aware that this authorization to release information may include information regarding HIV or AIDS, alcohol or drug abuse and/or psychiatric treatment.

_____ Please initial to indicate approval of the above paragraph.

I acknowledge financial responsibility for all facility and physician(s) fees. I understand that the physician will file my insurance claim if my physician is a participating provider with my insurance carrier and I assign direct payment to the physician all payments made under the terms and provisions of my policy. Otherwise, the physician will provide me with sufficient information to file my own insurance claim. I understand that I am responsible for and will pay my portion of the unpaid balance due for services performed by the facility and physician(s).

SIGNATURE_____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____

(Consent for minors or others unable to give consent)

DATE _____

WELCOME!

Insurance Acceptance Policy: We will file your insurance claim if the patient is covered by an insurance with which we have a contract and our physician is a provider. In other cases, we require payment in full at time of service. We accept cash, check and all Major Credit Cards.

OFFICE USE ONLY:

PATIENT INFORMATION: (please print legibly)

NAME: _____ _____ _____ _____
LAST FIRST MI TODAY'S DATE

MAILING ADDRESS: _____

ZIP: _____ CITY/STATE: _____

PHONE: ( ) _____ DATE OF BIRTH _____

EMAIL: _____

SEX: _____ RACE: ___ African Amer./Biack ___ Hispanic MARITAL STATUS: ___ Single ___ Separated
___ Asian/Pacific Islander ___ Amer. Indian/Alaskan Native ___ Married ___ Divorced
___ White (Non-Hispan1c) ___ Other ___ Widowed

EMPLOYER NAME _____ PHONE: ( ) _____

EMPLOYER ADDRESS _____

EMPLOYER ZIP: _____ CITY/STATE: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ HOME PHONE: ( ) _____
WORK PHONE: ( ) _____

PATIENT RELATIONSHIP TO EMERGENCY CONTACT: _Child _Other _Spouse _Friend _Grandchild _Parent _Relative _Self _Significant Other

GUARANTOR / RESPONSIBLE PARTY INFORMATION (if different from patient):

NAME: _____ _____ _____
LAST FIRST MI

PATIENT RELATIONSHIP TO GUARANTOR: ___Child ___ Other ___ Spouse ___ Student ___ Self

DATE OF BIRTH: _____ PHONE: ( ) _____

MAILING ADDRESS: _____

ZIP: _____ CITY/STATE: _____

INSURANCE INFORMATION: PRIMARY SECONDARY

INSURANCE NAME: _____ _____

POLICY NUMBER: _____ _____

GROUP NUMBER: _____ _____

SUBSCRIBER NAME: _____ _____

SUBSCRIBER EMPLOYER _____ PHONE: ( ) _____

EMPLOYER ADDRESS _____

EMPLOYER ZIP: _____ CITY/STATE: _____ OCCUPATION: _____

PLEASE TURN FORM OVER & READ THE STATEMENT. SIGN AND DATE THE FORM.