CONSENT FOR MEDICAL CARE

Permission is granted to the physicians and employees of Hilliard Family Medicine, Inc. to do such procedures as may be necessary to diagnose, treat, and care for the needs of myself, or of my dependent.

FINANCIAL RESPONSIBILITY

I agree to pay Hilliard Family Medicine, Inc. accounts on myself and/or my dependent for the services rendered when they are presented to me.

If I have medical insurance on myself and/or my dependent, I hereby authorize those benefits to be paid directly to Hilliard Family Medicine, Inc. I will pay all co-payments to the receptionist prior to my appointment. I understand that I am responsible for any balance that the insurance does not cover.

Accounts can be conveniently paid by CASH, PERSONAL CHECK, or CREDIT CARD.

There is a service charge of $25.00 on all checks returned for insufficient funds.

I am responsible to notify this office of any insurance changes, including change of primary care providers. I will notify this office of address and phone number changes.

RELEASE OF INFORMATION FOR BILLING

I authorize Hilliard Family Medicine, Inc. to release any medical information that may be necessary for processing my insurance claim to my insurance company.

Patient Name: _____ Date: _____
(Please Print)

Signature of Responsible Party or Guardian: _____

Assignment of Direct Payment to
Hilliard Family Medicine, Inc.:_____

Witness: _____

(NOTICE TO INTERNET USERS: If printing this form from our website, please sign this page in the presence of Hilliard Family Medicine employees at the time you deliver your registration forms for processing. Thank you!)