**METROPOLITAN FAMILY CARE, INC.** Today’s Date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**REGISTRATION FORM**

(Please PRINT)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Last Name: | | | | | | | | First: | | | | | | | | | | | Middle: | | | | | | | | * Mr. * Dr. | | | | | | | * Mrs. * Miss. | | | | * Sr. * Jr. |
| Street Address | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | State | | | | Zip Code | |
| Home Phone #: | | | | | | | | Work/Cell Phone #: | | | | | | | | | | | | | E-mail Address: | | | | | | | | | | | | | | | | | |
| **Birth Date** | | | | **Age** | | | | | | | **Social Security Number** | | | | | | | | | | | | | | | **Marital Status** | | | | | | | | | **Sex** | | | |
| **/ /** | | | |  | | | | | | |  | | | | | | | | | | | | | | | * Single * Widowed * Married * Divorced | | | | | | | | | * Male * Female | | | |
| **Emergency Contact** | | | **Name:** | | | | | | | | | | | | | | | **Relationship:** | | | | | | | | | | | | **Phone#:** | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Occupation: | | | | | | | | | | | | | | Insured Employer | | | | | | | | | | | | | | | | | | | | | | | | |
| Insured Employer Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please Indicate Primary Insurance** | | | | | | | | Address of Primary Insurance Carrier | | | | | | | | | | | | | | | | | | | | | | | | Phone Number | | | | | | |
| Insured Name | | | | | | Insured SSN # | | | | | | | | | | Insured ID # | | | | | | | | Policy Group # | | | | | | | | Effective Date | | | | | Co-Payment $ | |
| Patient’s Relationship to Insured | | | | | | | | | * Self | | | | | | * Spouse | | | | | | | | * Child | | | | | | * Other | | | | | | | Insured Birth Date | | |
| Insurance Type | | * PPO * HMO | | | | | * EPO * POS | | | | | | * Self-Pay * Medicare | | | | | | | | | * Public Aid * WC | | | | | | | | * OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Please Indicate Secondary Insurance | | | | | | | Address of Secondary Insurance | | | | | | | | | | | | | | | | | | | | | | | | Phone Number: | | | | | | | |
| Insured Name | | | | | | Insured SSN # | | | | | | | | | | Insured ID # | | | | | | | | Policy Group # | | | | | | | | Effective Date | | | | | Co-Payment $ | |
| Patient’s Relationship to Insured | | | | | | * Self | | | | | | * Spouse | | | | | | | * Child | | | | | | * Other | | | | | | | | | Insured Birth Date | | | | |
| **DEMOGRAPHCS (FOR GOVERNMENTAL STATISTICAL ANALYSIS)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Race: | * American Indian/ Alaska Native * White | | | | | | | | | * Asian * Hispanic | | | | | | | * Native Hawaiian * Other Pacific Islander | | | | | | | | | | | * Black or African American * I Decline to Report | | | | | | | | | | |
| Ethnicity: | * Hispanic | | | | | * Non-Hispanic | | | | | | | | | | | | * I Decline to Report | | | | | | | | | | | | | | | | | | | | |
| Preferred  Language: | * English | | | | * Spanish | | | | | | | | | | | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |

**AUTHORIZATION FOR ASSIGNMENT X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OF BENEFITS** Signature Date

**HIPAA AUTHORIZATION X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATA BASE SHEET**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | | | Age: | | | Today’s Date: | | | | | |
| Height: | Weight: | | Occupation: | | | | | | | | | | | |
| **Check If You Have Ever Had:** | **YES** | **NO** |  | Have you ever been admitted to a hospital? | | | | | | | | | | |
| TB (Tuberculosis) |  |  |  | **Date:** | | | **Problem:** | | | | | | | |
| Rheumatic Fever |  |  |  | 1. | | |  | | | | | | | |
| VD, Gonorrhea, or Syphilis |  |  |  | 2. | | |  | | | | | | | |
| Anemia or Low Blood |  |  |  | 3. | | |  | | | | | | | |
| Cancer or Tumor |  |  |  | 4. | | |  | | | | | | | |
| Leukemia |  |  |  | 5. | | |  | | | | | | | |
| Heart Attack |  |  |  |  | | | | | | | | | | |
| High Blood Pressure |  |  |  | **Habits** | | | | | | | | **YES** | | **NO** |
| Stroke |  |  |  | Do you Smoke? (How many/day) | | | | | | | |  | |  |
| Heart Murmur |  |  |  | Cigarettes | | | | | | | |  | |  |
| Asthma |  |  |  | Cigars | | | | | | | |  | |  |
| Emphysema |  |  |  | Pipe | | | | | | | |  | |  |
| Bronchitis |  |  |  | Marijuana | | | | | | | |  | |  |
| Pneumonia |  |  |  | Do you Drink? (How many/day) | | | | | | | |  | |  |
| Allergies, Hay Fever, or Sinus |  |  |  | Beer | | | | | | | |  | |  |
| Sugar Diabetes |  |  |  | Liquor | | | | | | | |  | |  |
| Ulcer |  |  |  | Wine | | | | | | | |  | |  |
| Colitis |  |  |  | Mixed Drinks | | | | | | | |  | |  |
| Yellow Jaundice |  |  |  | Coffee | | | | | | | |  | |  |
| Hernia (Rupture) |  |  |  | Tea | | | | | | | |  | |  |
| Goiter, or Thyroid Problems |  |  |  | Pop | | | | | | | |  | |  |
| Seizures, Convulsions, or Fits |  |  |  | Have you lost weight? | | | | | | | |  | |  |
| Nervous Condition |  |  |  | Have you gained weight? | | | | | | | |  | |  |
| Arthritis |  |  |  | Do you exercise? | | | | | | | |  | |  |
| Gout |  |  |  | What kind of exercise? | | | | | | | | | | |
| Blood Clot in Leg |  |  |  |
| Kidney or Bladder Infections |  |  |  |
| Kidney Stones |  |  |  | Do you do drugs? | | | | | | |  | | |  |
| Reaction to Any Medicine |  |  |  | Have you ever been Pregnant? | | | | | | |  | | |  |
| **What Medicine?** | | |  | How Many Times? | | | | | | | How Many Children Now? | | | |
| **Any Other Disease? (Not Listed Above)** | | |  |  |  | | | | |
| Do You Take Any Kind of Prescribed or Non-Prescribed medicine? (Including Aspirin, Tylenol, Laxatives, Antacids, etc.) |  |  |
| **Name of Medicine** | **How Often?** | |  | **Has any Blood Relative Had:** | | | | **YES** | | | **NO** | | **Relationship** | |
| 1. |  | |  | TB (Tuberculosis) | | | |  | | |  | |  | |
| 2. |  | |  | High Blood Pressure | | | |  | | |  | |  | |
| 3. |  | |  | Heart Trouble | | | |  | | |  | |  | |
| 4. |  | |  | Kidney Disease | | | |  | | |  | |  | |
| 5. |  | |  | Sugar Diabetes | | | |  | | |  | |  | |
| 6. |  | |  | Cancer or Tumor | | | |  | | |  | |  | |
| 7. |  | |  | Anemia or Low Blood | | | |  | | |  | |  | |
|  |  |  |  | Gall Bladder Problems | | | |  | | |  | |  | |
|  |  |  |  | Asthma or Hay Fever | | | |  | | |  | |  | |
|  |  |  |  | Thyroid Problems | | | |  | | |  | |  | |
|  |  |  |  | Glaucoma | | | |  | | |  | |  | |
|  |  |  |  | Others: | | | |  | | |  | |  | |

Metropolitan Family Care, Inc.

3341 East Livingston Avenue, Suite D

Columbus, Ohio 43227

Phone: (614) 237-1067 Fax: (614) 237-2655

**HIPAA FORM**

**As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have the right to request that communications concerning your personal health information is made through confidential channels. Metropolitan Family Care, Inc. will not ask you why you are making your request, and will try to accommodate all reasonable requests.**

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(Print Name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment, or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

**Please Select All That Apply.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Phone** | | | | | | | | |
|  | I want you to contact me at the following number: | | | | | | | | |
|  |  | **DO** |  |  | **DO NOT** | Leave messages on my answering machine. | | | |
|  |  | **DO** |  |  | **DO NOT** | Leave messages with any other person at this number. | | | |
|  | I want you to contact me at this secondary number: | | | | | | | | |
|  |  | **DO** |  |  | **DO NOT** | Leave messages on my answering machine. | | | |
|  |  | **DO** |  |  | **DO NOT** | Leave messages with any other person at this number. | | | |
|  | **Mail** | | | |  | | |  |  |
|  | I want you to contact me at the following address: | | | | | |  | | |
|  |  | | | | | |  | | |
|  |  | | | | | |  | | |
|  |  | | | | | |  | | |
|  | **Other requests for confidential communications. (Please Specify)** | | | | | | | | |
|  |  | | | | | | | | |
|  |  | | | | | | | | |
|  |  | | | | | | | | |

|  |  |
| --- | --- |
| **Date:** | **Signature:** |
|  | **Print Name:** |
|  | **If not signed by the patient, please indicate relationship:** |
|  |  |

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**Our Financial Policy**

*We are dedicated to providing the best possible care for you. We want you to completely understand our financial policies.*

1. We accept cash, check, debit or credit cards with the Visa or MasterCard logo and Discover Card. If you come to your appointment without the proper insurance cards, necessary identification or your co-payment you will be rescheduled. Any payments made by phone will be charged an additional $1.50 to process your payment.
2. We have made prior arrangements with many insurance companies to accept an assignment of benefits. You are required to pay your co-payment at the time of your visit. We will bill your carrier.
3. Please keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor- in other words; you agree to have your insurance company pay the doctor directly. If you insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment to you directly. Therefore, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the even your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all physician services provided in the hospital or office. You are responsible for any balance due.
7. Because of the limited time offered by your insurance to file a claim if no payment is received from your carrier within seventy (70) days from your date of service you will be financially responsible for the entire payment.
8. Any unpaid account(s) will be referred to an outside collection agency. Should further litigation become necessary, you will be assessed the attorney’s fee in order to resolve your debt.

*I have read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice as deemed necessary by the management.*

|  |  |
| --- | --- |
|  |  |
| Signature of Patient (or responsible party, if minor) | Date |
|  | |
| Please Print the Name of the Patient. |  |

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**CONSENT AND RELEASE OF INFORMATION**

**2014**

**MEDICARE PATIENTS**

I authorize any hold of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or related Medicare Claim. I permit a copy of this information to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment of this date of treatment.

**CONSENT TO TREATMENT AND RELEASE OF RESPONSIBILTY AND INFORMATION**

I (we) hereby consent and authorize the medical and/or surgical treatment, which is considered necessary or advisable in the judgment of the physician(s) while in Metropolitan Family Care, Inc. facilities. If I (we) refuse treatment or leave the medical practice contrary to the judgment of the physician(s), I (we) release the physician(s) of responsibility for the results of my action.

**I (WE) AM RESPONSIBLE FOR THE PAYMENT OF THIS TREATMENT**

I (we) authorize any approved medical insurance, which I have to make payment directly to the Metropolitan Family Care, Inc. and/or the physician. I (we) will pay any balance not covered by the approved medical insurance.

I (we) authorize the release of the medical practice records with information involving the medical treatment to the medical insurance carrier and family physician.

Signature (Patient/Guarantor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Witness)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Metropolitan Family Care, Inc.

**Practice Privacy Statement**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATIN.** This form is a federal mandate.

1. **This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice**. It is important that all patients and staff understand the importance of guarding patient information.
2. This practice has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results and other information that may be of a confidential nature. Patient information about health care is identified as “PHI” or protected health information. This change in policy requires that you, the patient, identify and clarify at the time of registration or re-registration with this practice who we can talk to, how we can leave information on your behalf, and the process for ongoing continuity of your medical care. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care or information from that point in time forward.
3. Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:
   * For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services such as lab, x-rays, other diagnostic testing or treatment related to your condition or medical care needs. This may also include conversations with other physicians.
   * For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.
   * For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
   * Appointment reminders and health related benefit services only with your consent identified on the registration form.
   * Disclosure to your family and friends concerning any related health care information with your on the registration form.
   * Disclosure to your family and friends concerning any related health care information with you on the registration form which can be modified at any time orally, followed by written consent.
   * **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity required immediate and full information for care on your behalf.**

Certain disclosures can be made without your consent, and they are as follows:

* Disclosure required by the government or law enforcement agencies. Specific areas that require release include gunshot wounds, domestic violence, and victims of abuse or neglect.
* Information used for public health purposes, medical examiners or related to a person’s death or for the health department for disease tracking.
* Information used for health care oversight, such as a site review by an insurance program.
* Information related to organ donation.
* Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
* Information provided to **avoid harm** if there is a threat to patient or other safety.
* Specific governmental functions.
* Workers compensation review.

1. Your rights with respect to your protected health information.

* The right to request limits on the uses and disclosure at registration or any time during your care.
* The right to choose how we send this information to you, including an alternate address.
* The right to see and obtain copies of this information, but there may be copy and postage fees.
* The right to get a listing of who we have made disclosures to about your PHI.
* The right to correct and update your filed through an amendment process if appropriate.

1. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 (sixty) days of the revision.
2. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.
   * Contact the office manager and complete a complaint form for review and discussion.
   * If you are not satisfied with this response, you may report the practice to:

Office of Civil Rights or GBA Palmetto

Regional Manager Part B Operations-HIPAA Compliance Concern

Department of Health & Human Services PO Box 182957

233 N. Michigan Avenue, Suite 240 Columbus, Ohio 43218

Chicago, Illinois 60601

(312) 886-1807

Metropolitan Family Care, Inc.

3341 East Livingston Avenue, Suite D

Columbus, Ohio 43227

Phone: (614) 237-1067 Fax: (614) 237-2655

**Receipt of Notice of Privacy Practices**

**Written Acknowledgement Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of the Notice of Privacy Practices for Metropolitan Family Care, Inc.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

Patient Unable to Sign Due to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Refused to Sign-Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

**2014**

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Metropolitan Family Care, Inc. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

* I understand that I have the right to revoke this authorization in writing at any time.
* I understand that it is **MY RESPONSIBILITY** to make Metropolitan Family Care, Inc. aware of any changes to this consent.
* I understand that certain information cannot be release without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

\_\_\_\_\_ Information regarding the patient’s diagnosis and treatment of HIV/AIDS

\_\_\_\_\_ Psychotherapy notes from a Psychiatrist or Psychotherapist.

\_\_\_\_\_ Treatment for alcohol or drug abuse reports.

\_\_\_\_\_ **I DO NOT AUTHORIZE** Metropolitan Family Care, Inc. to release any or all information concerning my medical care to any individual except as set forth above.

\_\_\_\_\_ **I AUTHORIZE** Metropolitan Family Care, Inc. to verbally release any or all information concerning my medical care to the following individuals.

|  |
| --- |
| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Patient Signature Date |

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**AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**\*\*PLEASE NOTE:** There is a fee for Records Transfer**\*\***

I hereby authorize the USE & Disclosure of any and all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS) information of:

Patient’s Name (**PRINTED**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person/Organization Authorized to **Release** Information: Person/Organization Authorized to **Receive** Information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the following dates of treatment (include specific description of information requested):**

For the Purpose of: \_\_\_\_\_ Further Medical Care

(Optional) \_\_\_\_\_ Insurance Billing

\_\_\_\_\_ Legal Reasons

\_\_\_\_\_Self

\_\_\_\_\_ Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed to a third party and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment or healthcare operations. I may inspect or copy any information used/disclosed **under this authorization.**

This authorization and request is fully understood and is made voluntarily on my part. I release the above-named facility of any legal liability that may arise from the release of the information requested.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. ***This authorization will expire automatically one year from the date on which it is signed.***Cancellation of this authorization prior to the limit must be made in writing to Metropolitan Family Care, Inc.

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Columbus, Ohio 43227

Phone: (614) 237-1067 Fax: (614) 237-2655

**Parental Consent for Medical Treatment of a Minor Child**

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Phone Number (If not at work or home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I (we), the parent(s) or guardian(s) named above, authorize the following adult caregiver to consent to any necessary examination, anesthetic, blood transfusion, medical diagnosis, etc. and/or hospital care to be rendered to the above-named minor child under the general or special supervision and on the advice of any licensed physician. I (we) agree to pay for all services provided to my child in my absence.

Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURES**

Parent or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN INFORMATION**

Child’s Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Allergies, including allergies to medicines, anesthetic, foods, etc.

Chronic or existing disease or medical problems (diabetes, epilepsy, etc.)

Medications child is taking (please include dose information)

Date of Last Tetanus Shot