Grove City Family Health Inc
Patient Information

Patient Information

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____ email: _____

Phone: _____ Cell: _____ Work: _____

Race: _____ Hispanic / Non-Hispanic (Circle One) Married Single (Circle One)

Date of Birth: _____ SS#: _____

Insurance Information

Insurance Company: _____
Primary Secondary

Insured's Name: _____
Last First Middle

Insured's Address: _____ City: _____

State: _____ ZIP: _____ Phone: _____ SS#: _____
Insured

Insured's Date of Birth: _____ Relationship to Patient: _____

Employer: _____ Phone: _____
Work Cell

Emergency Contact

Emergency Contact Name: _____ Relationship: _____

Address: _____

Phone: _____ Work Phone: _____ Cell Phone: _____

6024 Hoover Road Suite A Grove City OH 43123 PH: 614-875-8949 Fax: 614-539-4610

Gregory Runser, MD
Charles Baughman, MD
Mario Brunicardi, MD
Michael Harper, MD
John Horn, MD
Julia Stokes, MD
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6024 Hoover Road Ste, A
Grove City, Ohio 43123

Phone: (614) 875-8949
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Financial Acknowledgement

Name (Please print) Today's Date

Date of Birth SSN

☐ I am stating that I am a self-pay patient and I do not have health insurance and/or government issued health insurance assistance (such as Medicaid, Caresource, Molina, etc.). I will notify the practice immediately should I acquire insurance. I understand that if I provide false information, my dependants and I will be discharged from the practice.

I understand that if I am seeing a provider (physician/nurse practitioner), $50.00 will be collected on today's visit, if I am seeing a nurse $25 will be collected. There will be a 10% discount applied to the total bill, and the patient will be sent a statement for any remaining balance.

Signature Date

☐ I have health insurance but do not have my card with me. I understand I will be financially responsible for all charges on today's visit unless I present my insurance card within 30 days of todays visit.

Signature Date

Consent to Release Medical Information

Grove City Family Health

6024 Hoover Road, Suite A, Grove City ,OH 43123 614-875-8949

I _____ Date of Birth: _____

(PLEASE PRINT NAME)

Give Grove City Family Health permission to release my medical information to the following individuals.

Name: _____Date of Birth: _____

Relationship: _____ Phone #: _____

Name: _____Date of Birth: _____

Relationship: _____ Phone #: _____

Name: _____Date of Birth: _____

Relationship: _____ Phone #: _____

I Give Grove City Family Health permission to leave detailed medical information on my voice mail at the following phone number: _____

Signed: _____Date: _____

Witness: _____Date: _____

HIPAA Consent

Grove City Family Health

6024 Hoover Road, Suite A, Grove City ,OH 43123 614-875-8949

I _____ Date of Birth: _____

(PLEASE PRINT NAME)

Give my consent for Medical Care - Permission is hereby granted to the doctors, nurses and employees of Grove City Family Health, Inc to do such procedures as may be necessary to diagnose, treat and care for the needs of myself or my dependents.

I also give my consent for billing - I hereby authorize Grove City Family Health, Inc to furnish my insurance company, if applicable all information requested regarding my illness or injury. I also understand I am responsible for all outstanding balances deemed appropriate by my insurance company or all balances in the absence of a current policy.

By signing this form I am granting consent to Grove City Family Health, Inc to use and disclose my protected health information for the purposes of treatment, payment and health care operations. GCFH's Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our privacy officer at 614-539-7511

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signed: _____ Date: _____

Witness: _____ Date: _____