Old Harding Pediatric Associates (OHPA)
Consent to Treat and Financial Responsibility Form

PATIENT Name:_____

Patient's Date of Birth:_____ Patient's SS#:_____

I agree for OHPA to provide medical care to the patient named above whenever the patient presents at any OHPA office in need of care.

In addition I agree to act as the **financially-responsible and statement recipient** for the patient named above. I agree to provide accurate, timely and complete insurance information concerning the patient. I agree to pay OHPA for all medical expenses the insurance plan(s) deem **patient responsibility,** such as copays, co-insurance, deductibles and costs of non-covered or excluded services. If there is another adult with whom I share financial-responsibility, I agree to be the billed party and to provide the other person with the account information necessary for that person to pay OHPA.

Collection and legal fees will be added to any uncollected balance due OHPA if this account is sent to a collection agency.

This agreement is effective as long as the patient named above is provided services at Old Harding Pediatric Associates.

Parent/Guardian Name:
_____

Parent/Guardian Date of Birth _____

Parent/Guardian SS # _____

Home Mailing Address _____

_____ **ZIP**_____

Relationship to Patient named above _____

Parent/Guardian Signature _____ **Date signed**_____

***OHPA Employee: INITIAL HERE** _____

Revised (2/10/14)