Hancock Public Health Consent for Service and Financial Responsibility
2225 Keith Parkway, Findlay, OH 45840
419-424-7441 option 2

Patient Name & Date of Birth: _____

I, the undersigned, hereby certify and attest that I have agreed to the medical treatment, testing or to receive vaccines at Hancock Public Health. I therefore authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company I provided for the purpose of determining and receiving benefits for medical bills. I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required. I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided.

Patient/Responsible Party Signature/Date: