OXFORD OB/GYN, INC.
5225 Morning Sun Road Suite A, Oxford, Ohio 45056 Phone: (513) 523-2158 Fax: (513) 523-0019

Date:_____

Patient: _____

DOB: _____

Age: _____

As the parent/legal guardian, I give my permission for the clinicians of Oxford Ob/Gyn, Inc. to treat _____.

Additionally, I agree to pay all applicable charges which are not paid in full by the healthcare insurance. I understand that if the healthcare insurance fails to pay Oxford Ob/Gyn for any reason, I am still responsible to Oxford Ob/Gyn for all medical services provided. If amounts due to Oxford Ob/Gyn are not paid within 60 days of receipt of account statement, the account shall be deemed delinquent. In the event that I default on payment of the account, I understand that I am responsible for any and all costs incurred on the collection of the account, including court costs and reasonable attorney fees. If assigned to a third party for collections, I agree to be responsible for collection fees (including reasonable attorney fees).

Printed Name Telephone number

Relationship to Minor

Signature Date

State of _____ County of _____
The foregoing instrument was acknowledged before me this _____day of _____, 20____, at _____, _____, by _____ to be his/her free act and deed.

_____
Signature of Notary Public
Name of Notary Public _____
Notary Public, State of _____
My commission expires: _____