

Optimal Health Physicians

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Authorization & Agreements

Please read and sign the following documents.

- Authorization to Treat
- Payment Agreement
- Resolution of Concerns
- Release of Information
- Credit Card Authorization

These forms may be filled out on your computer, then printed and either faxed or mailed to OHP.

Patient Name (First, MI, Last) _____

Patient Date of Birth (Month/Day/Year) _____

Patient Address _____

City _____ State _____ Zip _____

Phone:

Primary

Home: _____

Mobile: _____

Work: _____

If these forms are to be signed by a person other than patient, give name and state the relationship to patient:

Name of Person Signing _____

- Parent Legal guardian Medical power of attorney (CLICK BOX OR ✓)