Photo ID and Insurance Card Copy Consent Form

Sovereign Direct Primary Care
7293 Sawmill Road, Dublin, OH 43016
614-300-5450

Patient Name: _____

Date of Birth: _____

Purpose of this Form

Sovereign Direct Primary Care (DPC) requests a copy of your photo identification (e.g., driver's license, passport) to verify your identity and maintain accurate patient records. Additionally, if you wish to utilize your insurance for prescriptions, imaging, specialists, labs, or other services outside the scope of your DPC membership, a copy of your insurance card is required so that we may coordinate with your insurance provider. This form documents your consent for us to copy, store, and use these documents as described below.

1. **Consent to Copy Photo ID**

I authorize Sovereign DPC to make and retain a copy of my photo identification for the purpose of verifying my identity and ensuring the security of my medical records. I understand that this is a standard practice to prevent identity fraud and maintain accurate patient information.

2. **Consent to Copy Insurance Card**

I authorize Sovereign DPC to make and retain a copy of my insurance card. I understand that Sovereign DPC operates as a Direct Primary Care practice and, other than direct Medicare beneficiaries, does not bill insurance for services covered under my DPC membership. However, if I choose to utilize my insurance for prescriptions, imaging, specialists, labs, or other ancillary services not included in my membership, providing a copy of my insurance card is mandatory. I authorize Sovereign DPC to coordinate with my insurance provider as needed to facilitate these services on my behalf. If I do not provide an insurance card, I understand that I will be responsible for arranging and paying for

such services independently, and Sovereign DPC will not interact with my insurance provider.

3. **Privacy and Security**

I understand that Sovereign DPC will protect copies of my photo ID and insurance card in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Ohio state privacy laws. These documents will be stored securely (e.g., in an encrypted electronic health record system) and accessed only by authorized personnel for the purposes outlined above.

4. **Retention and Destruction**

I acknowledge that Sovereign DPC will retain copies of my photo ID and insurance card for the duration of my membership and as required by law or practice policy. Upon termination of my membership or at my written request (where permitted by law), these copies will be securely destroyed in accordance with HIPAA and Ohio regulations.

5. **Right to Refuse or Revoke**

I understand that providing a photo ID is required for identity verification as a condition of enrollment with Sovereign DPC. Providing an insurance card is optional unless I wish to utilize my insurance for prescriptions, imaging, specialists, labs, or other external services, in which case it is mandatory for Sovereign DPC to coordinate with my insurance provider. I may revoke this consent for future use of my insurance card in writing at any time, understanding that this will mean I can no longer rely on Sovereign DPC to coordinate insurance-related services on my behalf.

6. **Acknowledgment**

I have read and understand this Photo ID and Insurance Card Copy Consent Form. I have had the opportunity to ask questions and have received satisfactory answers. By signing below, I consent to Sovereign DPC copying and storing my photo ID and, if applicable, my insurance card as outlined herein.

Patient Signature: _____

Date: _____

Practice Representative Signature: _____

Date: _____