

**DEPENDENT REGISTRATION AND FINANCIAL AGREEMENT FOR ACCESS TO WILCE PHARMACY**

Ohio State Students: Use this form to register your dependent(s) to have their prescriptions filled at the Student Health Services Pharmacy located within the Wilce Student Health Center. Co-pay or co-insurance amounts are due at the time of service. **If you are not covered by a participating prescription plan or have not paid your Student Health Insurance premium in full, then payment in full is required prior to receipt of the medication.** Please print and provide all requested information.

**Student Information**

Last Name:	First Name & Middle Initial:	OSU Student ID Number:
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Street Address, City, State, Zip Code:
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Email Address:	Telephone Number:	Date of Birth:
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**Dependent Information**

A Dependent is:

1. The student's legal spouse;
2. The student's same- or opposite-sex domestic partner;
3. The student's unmarried children. The term "children" includes a student's biological children; stepchildren; foster children; adopted children from the date of placement in the student's home and who depend on the student for their support; children which the student has been granted legal custody; children which the student has legal obligation to provide coverage due to a court order; and children of the student's domestic partner.

Last Name:	First Name:	Relationship:	Sex:	Date of Birth:

**STUDENT PLEASE READ CAREFULLY AND SIGN:**

I understand I am fully and solely responsible for any and all debts incurred by my legal spouse, domestic partner, and/or dependent children at the Wilce Student Health Center Pharmacy. *Failure to pay any co-payments, co-insurance, uncovered expenses, or any other expenses will result in collection efforts including, but not limited to, placing a hold on all Ohio State accounts, records, registration, and graduation.* I understand that any false statement or misrepresentation made on this form will result in loss of coverage under the Ohio State Student Health Insurance Plan and/or access to Wilce Pharmacy if covered by another insurance plan or not insured. In addition, I authorize the release of any and all information for processing claims for my minor dependents (17 years of age or younger).

Student signature \_\_\_\_\_ Date \_\_\_\_\_

**SPOUSE/PARTNER AND/OR CHILDREN 18 YEARS OF AGE OR OLDER, PLEASE READ AND SIGN:**

I authorize release of any and all information for processing of claims/charges.

Signature \_\_\_\_\_ Date \_\_\_\_\_