



PATIENT CONSENT, ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT

Patient/Client Name _____ Patient/Client ID # _____ (if applicable)

Consent for Treatment & Use of Records

I, the undersigned, voluntarily consent to treatment by the practitioners and clinical staff of the University Health Center. I also voluntarily consent to the use and disclosure of my protected health information (PHI) for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) without a written authorization.

I understand that in cases of disclosure of threats to harm myself or others, or instances of past or present child neglect or abuse, disclosure and/or mandated reporting may follow in accordance with State law and/or University policies and practices.

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me.

In the event that this visit is based on a Worker's Compensation claim and my Worker's Compensation claim is not accepted, I agree to have the fees associated with services sent to my private health insurance company.

I acknowledge that not all services provided by the University Health Center are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of the Health Center as an out-of-network provider, and/or my failure to provide my insurance card.

Authorization (PLEASE COMPLETE):

I authorize payment directly to the University Health Center for services for which the University Health Center accepts payment. I accept responsibility for all charges if I do not have medical insurance.

Patient Signature

Date

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my student until they turn 18. The Health Center will seek to notify parents in the event of an emergency.

Parent or Legal Guardian Signature for a minor

Date

Witness Signature

Date