ARKANSAS STATE UNIVERSITY

CONSENT TO TREATMENT

CONSENT: I am aware or have been advised that I (or the patient named below) am (is) suffering from a condition warranting medical treatment. I have been informed of the treatment and procedures considered necessary and I voluntarily consent to said treatment and procedures by the staff of the Arkansas State University Student Health Center. I have disclosed to the staff my medical history including any medication, drugs, or alcohol I have taken.

PRACTICE OF MEDICINE: I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as results of an examination or treatments which have been performed in the A-State Student Health Center.

INAPPROPRIATE BEHAVIOR: Civility and respect are extended to and expected of all persons. Rudeness or improper conduct will result in removal from the premises and discontinuation of any and all services provided by the Student Health Center. I understand and agree that inappropriate behavior such as outburst of anger, threatening behavior, or violence will not be tolerated in the A-State Student Health Center and will be reported to the proper personnel. **Initials -** _____

PERSONAL VALUABLES: I understand and agree that the A-State Student Health Center shall not be liable for the loss or damage to any personal property which I bring into the Center. Personal Property includes but is not limited to money, jewelry, eye glasses, watches, purses, wallets, backpacks, notebooks, and books.

FINANCIAL AGREEMENT: The A-State Student Health Center works hard to provide the highest quality care to you. The medical services I seek imply an obligation on my part to ensure payment is made for services received. I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services. For example, if further lab work is obtained based on the results of test(s) performed, additional charges will be placed on my Student Account.
Initials - _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize the A-State Student Health Center and any of its personnel to disclose and release all medical information relating to my treatment to any person or corporation which is or may be liable for all or part of the charges including insurance companies, workers' compensation carriers, welfare funds, Social Security Administration or its intermediaries or carriers.

I certify that I have read and understand this document and agree to its terms. If the undersigned is signing as the patient's representative he/she hereby certifies that the patient is personally unable to because of _____ and that the undersigned bears the relationship of _____ to the patient and is legally authorized to execute this document and accept its terms.

_____ _____

Patient **Date**

_____

Representative

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the Clinic's Notice of Privacy Practice.
(Patient Name, Please Print)

_____ _____
Signature of Patient or Legal Guardian Date

If not signed by the patient, please indicate the relationship;

- Parent or Guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or Personal Representative of the deceased patient

I would like to receive a copy of any amended Notice of Privacy Practices Yes No
(If yes, please remove last page.)

Third Party Access (Optional)

Patient Name _____ Date of Birth ____/_____/_____

I authorize the release of my Protected Health Information (PHI) to the following;

Name: _____ Phone: _____

If the above individual contacts us, they will provide your date of birth. Please make sure they know this information. Anyone who is not named above and who cannot provide your date of birth will be denied access to your Protected Health Information.

- I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties by the authorized person to whom it was disclosed by ASU and is no longer protected. I hereby release ASU from any and all liability resulting from any disclosure made by an authorized person to whom the information was properly disclosed by ASU to any unauthorized parties.
- I understand I may revoke the authorization at any time by signing the revocation section of this form and returning it to the Clinic. I further understand such revocation does not apply to the extent of persons authorized to use or disclose my health information who have already acted in reliance on this authorization.
- I understand I am under no obligation to sign this authorization. I further understand my ability to obtain treatment will not depend in any way on whether or not I sign this authorization.
- I understand I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.
- I understand the Clinic, ASU Student Health Center, will not receive compensation for the uses and disclosures I have authorized.

Signature _____ Date _____

REVOCATION SECTION

I hereby revoke this authorization _____ Date _____

Revocation received by the clinic _____ Date _____