

**Payment:** I, \_\_\_\_\_ *understand any charges incurred during my office visit today, will be charged to my Student Account.*

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Reason for visit \_\_\_\_\_

Address \_\_\_\_\_ Birthday \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_ Name of Pharmacy \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone # \_\_\_\_\_

**Check One:**

White \_\_\_\_\_ Asian \_\_\_\_\_ Hispanic \_\_\_\_\_

Black \_\_\_\_\_ Other \_\_\_\_\_

**Check one:**

Male \_\_\_\_\_

Female \_\_\_\_\_

Student ID# \_\_\_\_\_

**Insurance not Billed. Carrier for Referral Purposes.**  
Medicaid Y/N \_\_\_\_\_ Private Insurance Y/N \_\_\_\_\_

## 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 (ASU) Student Health Center. I have disclosed to the Center 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 a result of the examination or treatments which have been performed in the ASU 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 outbursts of anger, threatening behavior, or violence will not be tolerated in the ASU Student Health Center and will be reported to the proper personnel. Initials - \_\_\_\_\_

**PERSONAL VALUABLES:** I understand and agree that the ASU 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, contact lenses, watches, purses, wallets, back packs, satchels, documents, notebooks, and books.

**FINANCIAL AGREEMENT:** The undersigned agrees, when he/she signs as the patient, in consideration of the services to be rendered to the patient, that he/she is hereby responsible for all charged services rendered by any and all providers at the ASU Student Health Center. The undersigned certifies that if he/she has signed as the patient's representative that he/she is authorized under the law to represent the patient. If the undersigned has signed as the patient's representative only, the undersigned is not financially responsible unless so obligated by law.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I authorize the ASU 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 Center charges including insurance companies, workers' compensation carriers, welfare funds, the 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 sign 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

**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 \_\_\_\_\_

**REVOCACTION SECTION**

I hereby revoke this authorization \_\_\_\_\_ Date \_\_\_\_\_

Revocation received by the clinic \_\_\_\_\_ Date \_\_\_\_\_