SOUTH DAKOTA STATE UNIVERSITY

Student Health Clinic and Counseling Services
1440 N Campus Dr, Box 2818, Brookings, SD 57007
Phone: (605) 688-4157 Fax: (605) 688-6450

Patient Information:

Name: _____ Date of Birth: _____

Student ID: _____ Cell Phone: _____

Billing Address: _____

Insurance Information:

Company Name: _____ Policy Holder Name: _____

Assignment of Payer Benefits

I agree SDSU Student Health Clinic and Counseling Services will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers will make payments directly to SDSU Student Health & Counseling Clinic. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to SDSU Student Health Clinic & Counseling Clinic. I agree that unless SDSU Student Health Clinic and Counseling Clinic has agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to copayments, deductibles, co-insurance amounts and charges for non-covered services. You will be charged a $20.00 charge for nonsufficient funds checks. **Missed Appointment Fee for Health and Counseling:** I understand I will be charged a $15.00 fee for any missed appointments. **Electronic signature agreement. By checking "I accept box" you are signing this agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature. You further accept that you are legally bound by this Agreement's terms and conditions.**

***Signature:** _____ **Date**_____

Acknowledgement

I (the member/patient or if a minor, guardian of the member as listed above) **acknowledge** that the SDSU Student Health Clinic **does NOT accept: Medicare, Medicaid or Workman's compensation**. Any Health care services or supplies that I have requested will not be covered under the terms of my Health Care plan if it is one of the above listed. No claims will be filed for these services.

.* Signature: _____ **Date**_____

Medical Consent

The undersigned hereby authorizes the provider to render any services that the treating Provider determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Services. The undersigned acknowledges that no guarantees have been made as to the results of assessment and treatment.

Medical Insurance Benefits

The undersigned, hereby assigns to Provider all private medical insurance benefits (primary & secondary) or other benefits to which Patient may be entitled for any Services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of patient.

Disclosure of Health Information

I consent to the disclosure of my health information to non-SDSU Student Health Clinic and Counseling Services related health professionals or entities for treatment, billing, and other healthcare operations purposes. This consent will remain in effect unless revoked.

Email Consent

I consent to have my insurance card/policy information e-mailed unencrypted to and from SDSU Student Health via my student.

Jacks email address: _____

Acknowledgement

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

.* Signature: _____ **Date**_____