Appendix 21

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

USA Student Health Center

Patient Information

Patient's Last Name: _____ First: _____ MI: _____

Patient's Social Security Number: _____ -- _____--_____ Jag Number: J00_____

Patient's Date of Birth (mm/dd/yyyy): _____/_____/_____ Gender(please check) Male: _____ Female: _____Other_____

Patient's Address:
Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Patient's Phone Number:
Home: (____)_____ -- _____ Cell: (____) _____ -- _____ Carrier for text messages:_____

Email Address _____ Referred by: _____

Insurance Information:
Insurance Co: _____ Policy: _____ Grp:_____

Insured's Name Last Name: _____ First: _____ MI: _____
Insured's Address:
Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Insured's Telephone: (_____)_____ -- _____Insured's Employer: _____

Insured's Date of Birth(mm/dd/yyyy): _____/_____/_____ Relationship to Insured: Child, Self, Spouse, Other (circle)

Consent for Treatment:
I authorize USA Student Health Center and its agents permission to diagnose and treat my condition as deemed necessary.

Authorization to Release Information:
I authorize USA Student Health Center and its agents to acquire from or release to my health provider(s) or medical health care team and/or my insurance carrier any and all information required for the purposes of my care and/or for processing all medical claims.

Assignment of Benefits:
I authorize my insurance company or any financial agents processing my claim to make payments directly to USA Student Health. I also understand that should the payment be sent to me directly, I will financially responsible for the balance on the account.

Financial Obligation:
I understand that I may be responsible for any deductible, co-pay, non-covered or unpaid balances.
I understand that any outstanding balance on my account at USA Student Health could result in a "hold" being placed on my University Account. I understand this hold will prevent me from registering for class, receiving grades, or transferring my records to another university.

Signature of Patient or Guardian: _____ Date: _____