COLUMBUS STATE UNIVERSITY - STUDENT HEALTH CENTER

PATIENT INFORMATION

Patient Name (Last, first, middle initial)		Date of Birth	CSU ID#
Sex M F	Race	College Major	SS#
Local/Campus Address	City/State	Zip	Telephone No.
Emergency Contact Name and Address	Relationship		Telephone No.

INSURANCE INFORMATION

Company Name	Name of Insured (Policy Holder)	Date of Birth of Insured

Relationship of Patient to Insured: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

I hereby authorize the health center indicated above to furnish all medical records to my insurance carriers concerning my illness, condition and treatment, and I hereby irrevocably assign to the physician/provider all payments for medical services rendered to myself. I understand that I am financially responsible for all charges that may be incurred at the time of visit.

STUDENT SIGNATURE: _____ DATE: _____

As a service to you, our charges will be filed with your insurance company by our billing service.

PROVIDE YOUR INSURANCE CARD TO THE PERSON AT THE FRONT DESK

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES

I,_____, hereby authorize the Student Health Center, their agents and consultants, to perform diagnostic and treatment procedures, which in their judgment may become necessary while at Columbus State University. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of Columbus State University.

STUDENT SIGNATURE (If 18 or older): _____ DATE: _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received, read and understood the Student Health Center's Notice of Privacy Practices (Privacy Notice).

STUDENT SIGNATURE (If 18 or older): _____ DATE: _____

NOTICE OF CO-PAY POLICY PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received, read, and understood that I have received, read, and understood the Student Health Center's Co-Pay Policy.

STUDENT SIGNATURE (If 18 or older): _____ DATE: _____