CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS/ TREATMENT AGREEMENT

In our Notice of Privacy Practices (NPP) we provide you information about how Student Health Services can use or disclose your medical information. As described in our NPP, we request your consent for any use or disclosure of medical information to carry out treatment, payment, or health care operations. You have a right to review our NPP before signing this Consent.

By signing this Consent form you: (1) Acknowledge that a copy of the NPP has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the NPP.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed your health information in reliance upon this Consent.

I hereby give permission for treatment by the Physician, Nurse Practitioners, consulting medical providers, and staff of the Bryant Student Health Center.

PAYMENT AND ACKNOWLDEGEMENT OF CHARGES FOR MISSED APPOINTMENTS

For your convenience, we offer the following options for your payment: cash, personal check or credit card. If you are unable to pay at the time of service, you may discuss deferring your bill. ***This will include placing a hold on your transcript, grades, and your ability to enroll until you are able to pay the full amount.***

I understand that the charges for my appointment are to be paid in full at the time of check-out and that I am responsible for my complete bill. ***I understand that the Bryant Student Health Center does not bill insurance with the exception of the Student Injury and Sickness Insurance Plan through the State of Kansas.***

I understand that I will be charged for missed appointments for specialty services that are not cancelled at least 2 hours ahead of time. I also understand that the Student Health Insurance will not pay for missed appointments.

____ ___________________________________

Patient's Name (**Printed**) PSU ID

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Signature of Patient or Personal Representative

Personal Representative's relationship to Patient: ____

Personal Representative's Address and Phone Number: ____
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Below This Line: HEALTH OFFICE USE ONLY

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DOCUMENTATION OF GOOD FAITH EFFORT

Check the applicable box showing Good Faith Effort.

- ❑ Emergency situation. Provide patient with copy of NPP as soon as reasonable practicable after the emergency treatment situation.
- ❑ Patient/Legal Representative given NPP, but declines to acknowledge receipt.
- ❑ Patient/Legal Representative states that they have already received the NPP.
- ❑ Other: ____

____ ___________________________________

Employee Name (**Printed**) Date

____

Signature of Employee