COLUMBUS STATE UNIVERSITY - STUDENT HEALTH CENTER

PATIENT INFORMATION

Patient Name (Last, first, middle initial)	Preferred Name	Date of Birth	CSU ID# 909
Local Address	City/State	Zip	Cell #

☐ Male ☐ Female Identifies As:	Race	Ethnicity

CSU Email____@columbusstate.edu

Alternate Email____

Emergency Contact Name and Address	Relationship	Cell #

NOTICES, PERMISSIONS AND ACKNOWLEDGEMENTS

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.

Initial: _______________ Date: __________________

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: __________________

INSURANCE INFORMATION

Do you have the Columbus State United HealthCare Student Resource Insurance?

☐ Yes ☐ International

☐ No ☐ Domestic