Creighton
UNIVERSITY

Student Health Services/Student Counseling Services
Fax #: 402-280-1859

Consent to Treatment

CONSENT TO TREATMENT

Creighton University Student Health Services is staffed by physicians, physician's assistants and nurse practitioners. I (or the parent, legal guardian, or authorized representative of the patient) authorize you to provide reasonable and proper medical care to me/patient. That care may include testing for the human immunodeficiency virus (HIV).

FINANCIAL RESPONSIBILITY

I agree that I am responsible for payment of all charges for health care services provided to me. If applicable, I understand that an insurance card is necessary to validate my coverage for each visit. If I do not have my card with me, I accept financial responsibility for all services provided to me by Creighton University Student Health Services in the event that I am not covered for these services, and I understand that I will receive a bill for these services from Creighton University Student Health Services. Some insurance policies require a written referral from my primary care provider for specialist services to be covered. If I do not have that referral, I accept financial responsibility for the services provided to me by specialists that are not paid for by my insurer.

MEDICARE ASSIGNMENT OF BENEFITS

I certified that the information given to apply for Medicare Benefits is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid, its intermediaries or carriers, any information needed for this or related Medicare claims. I request that authorized benefits be paid on my behalf.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Creighton University Student Health Services to release all medical information (including, but not limited to, psychiatric conditions, sickle cell anemia, alcohol, drug abuse, HIV, or communicable diseases) requested by my health insurance carrier, Medicare, Medicaid or any other third-party payor. I authorize release of all medical information to my referring provider and my primary (family) provider. I authorize contact with my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy and direct said insurance company or health plan administrator to release such information to Creighton University Student Health.

I AGREE THAT THESE PROVISIONS WILL REMAIN IN EFFECT UNTIL I PROVIDE WRITTEN REVOCATION TO CREIGHTON UNIVERSITY STUDENT HEALTH SERVICES.

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Student Signature

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Parent/Guardian/Authorized Representative Signature
(Required if student under age 19)

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Today's Date

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Student NET ID