South Dakota State University Student Health Clinic and Counseling Services
Insurance Information

Please return the following information with a copy of both the front and back of your medical insurance card

Mail:

SDSU Student Health & Counseling
Patient Services Department
Wellness Center Box 2818
1440 N Campus Dr., Brookings, SD 57007

Email back to sender before your appointment

SDSU Student Health & Counseling
Attn: Patient Services Department
FAX 1-605-688-6450

Phone: 1-605-688-6900 or 605-688-6018

Patient Information

Name _____ Date of Birth _____ Student ID# _____

Patient Billing Address _____

City _____ State _____ Zip Code_____Phone#_____

Policy Information

Insurance Company Name _____

Insurance Company Address _____

City_____ State _____ Zip Code _____

Member ID# _____ Group #_____effective from:_____to_____

Policyholder Name _____

Policyholder Date of Birth _____ Relationship _____ ☐Male ☐Female

(Typically Your Parent, Guardian or Self)

Policyholder Street Address _____Phone#_____

City _____ State _____ Zip Code_____

PLEASE NOTE

1. **You** must contact your insurance company directly to determine how your specific plan processes and pays for services rendered at SDSU Student Health & Counseling.

2. **Insurance Referral** – If your insurance company requires pre-approval for services at SDSU Student Health & Counseling **it is YOUR Responsibility** to provide that information **PRIOR** to chargeable services being rendered so we can get the preauthorization for you. Unapproved charges will be **YOUR responsibility.**

3. **We DO NOT accept Medicare, Medicaid or plans underwritten by health insurance companies based outside of the United States.**

South Dakota State University Student Health Clinic and Counseling Services

ASSIGNMENT OF PAYER BENEFITS

I agree SDSU Student Health Clinic and Counseling Services will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers will make payments directly to SDSU Student Health & Counseling Clinic. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to SDSU Student Health Clinic & Counseling Clinic. I agree that unless SDSU Student Health Clinic and Counseling Clinic has agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to copayments, deductibles, co-insurance amounts and charges for non-covered services. You will be charged a $20.00 charge for nonsufficient funds checks. **Missed Appointment Fee for Health and Counseling:** I understand I will be charged a $15.00 fee for any missed appointments.

Electronic signature agreement. By checking " I accept box" you are signing this agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature. You further accept that you are legally bound by this Agreement's terms and conditions.

*Signature: _____Date_____ "I accept" Electronic signature☐

ACKNOWLEDGEMENT

I (the member/patient or if a minor, guardian of the member as listed above) **acknowledge** that the SDSU Student Health Clinic **does NOT accept: Medicare, Medicaid or Workman's compensation**. Any Health care services or supplies that I have requested will not be covered under the terms of my Health Care plan if it is one of the above listed. No claims will be filed for these services.* Signature: _____Date_____"I accept" Electronic signature☐

MEDICAL CONSENT

The undersigned hereby authorizes provider to render any services that the treating Provider determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Services. The undersigned acknowledges that no guarantees have been made as to the results of assessment and treatment.

MEDICAL INSURANCE BENEFITS

The undersigned, hereby assigns to Provider all private medical insurance benefits (primary & secondary) or other benefits to which Patient may be entitled for any Services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of Patient.

DISCLOSURE OF HEALTH INFORMATION

I consent to the disclosure of my health information to non-SDSU Student Health Clinic and Counseling Services related health professionals or entities for treatment, billing, and other healthcare operations purposes. This consent will remain in effect unless revoked.

EMAIL CONSENT

I consent to have my insurance card/policy information e-mailed unencrypted to and from SDSU Student Health via my student Jacks email address_____.

ACKNOWLEDGMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

_____Date_____relationship to patient_____"I accept" Electronic signature☐

Signature of Patient or Authorized Person
Updated 8/18/2020