CMU | Health
CENTRAL MICHIGAN UNIVERSITY

Student Health Services
600 E Preston – Foust 200
Mt Pleasant, MI 48859
Phone: 989-774-6599 Fax: 989-774-4335

Patient Information Form

Full Legal Name: _____ DOB: ____ /_____ /_____

CMU Email: _____@cmich.edu Phone:_____ CMU ID# _____

Billing Address: _____

City, State, Zip: _____

❑ Student ❑ Faculty/Staff ❑ Faculty/Staff Dependent ❑ Male ❑ Female

❑ Married ❑ Never Married ❑ Divorced ❑ Domestic Partner ❑ Significant Other ❑ Widowed

Ethnic Group: ❑ Hispanic ❑ Not Hispanic or Latino ❑ Prefer to Not Answer

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

❑ White ❑ Other: _____ ❑ Prefer to Not Answer

INSURANCE INFORMATION

REQUIRED: 1. Card/Policy Holder info below – this may not be the same as Patient
2. A copy of insurance card(s) both front and back

Insurance #1 CARD/POLICY HOLDER

Patient's Relationship to Policyholder: ❑Self ❑Child ❑Spouse ❑ Other: _____

Cardholder Name: _____

Date of Birth: _____ Phone:_____

Insurance Company Name & Address:

_____

_____

_____

Policy #: _____

Group #: _____

Insurance #2 CARD/POLICY HOLDER

Patient's Relationship to Policyholder: ❑Self ❑Child ❑Spouse ❑ Other: _____

Cardholder Name: _____

Date of Birth: _____ Phone:_____

Insurance Company Name & Address:

_____

_____

_____

Policy #: _____

Group #: _____

Consent for Treatment and Services

- I request and authorize health care services as my physicians, his/her assistants, and or designees (collectively called "the physicians") may deem necessary or advisable.
- This care may include, but is not limited to, routine diagnostic and laboratory procedures, administration of routine drugs and other therapeutics and routine medical and nursing care.

Release of Information and Authorization to Bill Insurance

- I authorize CMU Health to furnish information to insurance carriers concerning my illness and treatments – including mental health, substance abuse and HIV related disorders/diseases.
- I understand the insurance carrier may provide an Explanation of Benefits (EOB) to the Subscriber regarding services submitted for reimbursement if services are billed to my insurance.
- I hereby assign to the Physician(s) all payment for medical services rendered to me and/or my dependents.

Insurance Pre Authorization Requirement

- I understand some Insurance plans may require prior authorization/approval from my Primary Care Provider and that I may be responsible for obtaining this authorization. In the event that the authorization is not obtained or authorization is denied, I understand that I may become personally and fully responsible for all charges.

Payment Policy

- I assume full financial responsibility for payment of all services provided to me, including any portion of my bill which is not paid by insurance, workers' compensation or any other agency.
- Patient balances will be sent to patient directly via a monthly Billing Statement. Prompt payment is expected.
- CMU Student or Employee: If your account becomes past due and you are an active CMU student or employee, your past due balance will be transferred to Student Account Services and University Billing for collections and will be subject to CMU's delinquent account policy which includes monthly late fees of $30, transcript and registration hold, and collection costs of 23% if referred to an outside collection agency.
- Past due accounts will be referred to an outside collection agency. Patient will be responsible for all litigation and reasonable attorney's fees necessary for the collection of this debt. Once the account is referred to a collection agency, the past due account will be reported to the national credit bureaus.
- I authorize Central Michigan University and its agents and contractors to contact me at my current and any future cellular phone number(s), email address(es) or wireless device(s) regarding my outstanding account balance I owe Central Michigan University or its agents. I authorize the use of automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and emails, in their effort to contact me.

Acknowledgement of Receipt of Notice of Privacy Practices

- I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand CMU Health has the right to change this notice at any time. I may obtain a current copy by contacting CMU Health at 989-774-6599 or by requesting a copy in person at 600 E Preston / Foust 200, Mt Pleasant, MI 48859.

I have the right to revoke this consent in writing at any time except to the extent that CMU Health has taken action in reliance on this consent.

CONSENT TO DISCUSS CARE AND TREATMENT

IMPORTANT: PLEASE COMPLETE AND SIGN BELOW

- I authorize CMU Health to discuss and release any and all information regarding my care, treatment, services and billing to individuals listed below only. I may revoke or change this Consent in writing at any time.

Name: _____ Name: _____

Phone: _____ Relationship: _____ Phone: _____ Relationship: _____

- My signature below indicates understanding of the above:

Patient Signature: _____ Date: _____

Printed Name: _____

CONSENT FOR TREATMENT OF MINORS – Statement by Parent/Guardian for patients under age 18.

- I authorize medical treatment for my **minor child** that may be recommended by CMU Health.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____