Patient Name: ____Date of Birth_____________
(Please Print - Last Name, First Name, Middle Initial)

PAYMENT
I acknowledge it is my responsibility to pay for any services I receive from the MSU HealthTeam.

____
Signature Date

IF I HAVE INSURANCE, I acknowledge Michigan State University HealthTeam will disclose protected health information to my insurance carrier or other third party responsible for my bill as required in order to receive reimbursement for services provided. This information may include mental health treatment, genetic testing, and information about serious communicable diseases, such as STDs, hepatitis, HIV and AIDS.

I authorize and request assignment of benefits to be paid directly to Michigan State University. I acknowledge and agree to pay any unpaid balances not covered by my insurance policy, including deductibles, co-payments, and unauthorized or out of network services.

____
Signature Date

MEDICARE PATIENTS ONLY

I authorize and request that payment of authorized Medicare benefits be made to the MSU HealthTeam on my behalf for any services furnished to me by a provider of the MSU HealthTeam.

____
Signature Date

. . . .

MSU HEALTHTEAM NOTICE OF PRIVACY PRACTICE

I acknowledge that I have been offered the MSU HealthTeam Notice of Privacy Practices

______________________ ____________________________ ____________________
Patient Name (please print) Signature Date

. . . .

COMMUNICATION OF YOUR PROTECTED HEALTH INFORMATION

If you want us to speak with another individual about your care, please list their name, relationship to you, and phone number:

____
Name Relationship Phone Number

____
Signature Date