ARIZONA STATE UNIVERSITY

Last Name	
First Name	
ASU ID #	Date/Time

ASU HEALTH SERVICES PRACTICES

1) Notice of Privacy Practices Acknowledgement

ASU Health Services (AHS) follows the guidelines as stated in our Notice of Privacy Practices. Please acknowledge by signing below that you have received, or been given access to, a copy of the ASU Health Services Notice of Privacy Practices which can be found at www.asu.edu/health. Our Privacy Policy has been updated effective 9/23/2013.

2) Conditions of Treatment

I consent to the usual and customary medical evaluation and treatment, x-ray examinations, nursing and technical services, and laboratory procedures, which may be performed on me at ASU Health Services. I understand that certain physicians/health professionals furnishing services to me may be independent contractors and not employees of ASU Health Services. ASU Health Services is not liable for the actions or omissions of independent contractors. I understand that my medical records will be kept for 6 years following the last date of treatment.

I understand that as a patient of ASU Health Services I have certain rights and responsibilities. These rights and responsibilities are clearly posted throughout ASU Health Services and are also available on the ASU Health Services web site at www.asu.edu/health/ and in printed form upon request. Copies of the ASU Health Services policy regarding patient rights and responsibilities may be obtained from the office of the Director of ASU Health Services.

3) Financial Agreement

I understand that all services rendered to me at ASU Health Services will have fees associated with them whether or not I choose to utilize health insurance for payment. ASU Health Services may offer a "cash discount" for those who charge their visits directly to their student account.

I understand that my complete insurance information must be provided to ASU Health Services at the time the service is rendered or no later than 48 hours after my appointment in order to bill my insurance company.

I hereby authorize ASU Health Services to furnish information to insurance carriers concerning my illness, condition and treatment, and I hereby irrevocably assign to ASU Health Services all payments for medical services rendered to myself or my dependents. Although ASU Health Services may bill my insurance company, I understand that I am ultimately financially responsible for all charges that may be charged to my student account.

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4) Privacy Options

1) Opt-Out Option for Family Members **I understand that unless I Opt-OUT, ASU Health Services may share minimally necessary medical information with properly identified family members in order to assist in medical/emergency care and billing. If I Opt-OUT, ASU Health Services staff will not share information with family even when requested by family members. I understand that I can change my choice of sharing information in the future by notifying ASU Health Services in writing. If I am under 18, I understand that I cannot opt out of sharing medical information with my parents or legal guardian.**

☐ **I certify that I am 18 years or older and I choose to OPT-OUT of sharing of private medical information with family members.**

2) Additional/Alternative Designee to Receive Medical Information

☐ **I choose the following additional and/or alternative person(s) to receive my private medical information in order to assist in medical/emergency care**

Name-_____ **Relationship-** _____

Contact Phone #_____

3) Alternative Methods of Communication

ASU Health Services can utilize many methods to communicate with patients including communicating verbally, through the U.S. mail, telephonically, and through the use of secure email. I understand that ASU Health Services will not initiate communication via unsecure email or text messaging unless I choose to Opt-IN to utilization of these forms of communication.

☐ **I choose to OPT-IN for the following alternate methods to allow communication with me. I understand ASU Health Services will determine the best method of communication depending on the nature of the information.**

☐ **Unsecure Email-** _____@_____

☐ **Unsecure Text Messaging- (** _____ **)** _____ **-** _____

Patient Signature

Date