IOWA STATE UNIVERSITY
Thielen Student Health Center

2647 Union Drive
Ames, Iowa 50011
Phone: 515-294-5801
Fax: 515-294-5457

Medical Insurance Information

SUBMIT INSURANCE THREE WAYS:

1. *Scan and email to: submitinsurance@iastate.edu*
2. *Drop off at the Student Health Center, corner of Union drive and Sheldon Avenue*
3. *Mail to: Student Health, ATTN: Insurance Information, Thielen Student Health Center, 2647 Union Drive, Ames, Iowa 50011-2029*

Patient Information:

Patient Full Name:		
University ID#:	Date of Birth (MM/DD/YYYY):	Age:
Phone #:	Email Address:	

Eligibility Status: ☐ Undergraduate ☐ Graduate Assistant ☐ Post Doctorate ☐ Spouse ☐ Dependent

Student Status: ☐ Full-time ☐ Part-time (*Number of credits:* _____)

☐ I am **NOT** covered by any insurance polices. _____

STOP and SIGN statement - DO NOT complete rest of form. *Patient's Signature and Date*

☐ I have the following types of insurance: (*check all that apply*) ☐ **MEDICAL** ☐ **PHARMACY**

If the patient is covered under **more than one plan**, please **list the primary insurance** in the space provided below. **Provide any secondary insurance information** - such as the policy holder information for this secondary plan on the back of this form.

PLEASE ATTACH A COPY OF ALL ACTIVE INSURANCE CARDS (FRONT AND BACK).

Medical Insurance Information: (ALL INFORMATION BELOW IS REQUIRED)

Primary Policyholder's Full Name:		
Relationship to Patient:		
Phone Number:	Date of Birth (MM/DD/YYYY):	
Address:		
City:	State:	Zip:

Complete only if information is not located on copy of insurance card:

Insurance Company:	Phone Number:	
Address:		
City:	State:	Zip:
Policy Number:	Group Number:	

Complete only if this is a new policy:

Does this policy replace last year's policy? ☐ No ☐ Yes If yes, end date: _____

Name of previous insurance company: _____

On my behalf (or for my underage child), I authorize the release of any medical information necessary to process claims submitted to the insurance companies I have provided to the Thielen Student Health Center. I also authorize payment of benefits to the clinic/physician or supplier of services rendered indicated on the billing document.

Patient's Printed Name

Today's Date (MM/DD/YYYY)

Signature of Patient (or Legal Representative, if applicable)

If applicable, Legal Representative's Printed Name and Relation to Patient (e.g., Mother, Father, Guardian, etc.) or signature of witness (witness not required in Iowa, but may be in other states).

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Consent for Services and Communication

Medical & Psychiatric Services • Email & Text

I, the undersigned, expressly consent to my (the patient's) medical treatment, including:

1. I authorize the healthcare professionals of Thielen Student Health Center (TSHC) and their designees and business associates, to administer medical tests, diagnostic procedures, and perform treatment, as considered medically or therapeutically necessary.
2. I understand that TSHC may share medical information with the health insurance company(ies) I have identified as providing me with coverage, as may be necessary to process claims for medical services rendered to me.
3. I authorize payment of health insurance benefits to TSHC for medical services rendered to me.
4. I understand my continued treatment at TSHC is contingent on enrollment at Iowa State University (ISU). Prior to graduation or leaving ISU, I agree to cooperate with my TSHC treatment team to transfer my care, if they request.
5. I understand that more detailed information about my rights as a patient, and the way my medical information may be used or released, is described in TSHC's *Notice of Privacy Practices* (*NPP*) and that TSHC's *NPP* has been made available to me.

For psychiatric treatment, where applicable, I agree and understand that:

1. Treatment may include prescription and monitoring of psychotropic medications, lab monitoring, referral, psychoeducation, sleep hygiene, brief psychotherapy, and other necessary treatments.
2. I acknowledge TSHC cannot guarantee me specific results of psychiatric tests, treatments, or any other services rendered.
3. I understand my psychiatrist and/or pharmacist will provide me with information about known side-effects of any medication administered or prescribed.
4. I am aware there are exceptions to confidentiality of psychiatric records, as described in the NPP. These include but are not limited to:
    - The TSHC staff work as a team. My psychiatrist and psychiatric nurse may consult with another TSHC psychiatrist or family practice provider to provide me with the best possible care.
    - If I pose a threat of harm to myself and/or others, TSHC will take whatever steps are required or permitted by law to help prevent the harm from happening.

For phone, email, and text messaging I agree and understand that:

1. TSHC will use the contact information I have provided the ISU Office of the Registrar, including phone, address and email address.
2. TSHC may leave detailed appointment, medical care, test results, and billing information on voicemails at the phone number I provide to the ISU Office of the Registrar so long as the voicemail identifies me as the owner. Detailed messages will not be left on unidentified devices.
3. For my security and convenience, TSHC offers to communicate with me via encrypted email, including communications containing personally identifiable health information. Encryption best protects my health information. Encrypted email sent to my ISU sponsored email account will not look different from any other email. TSHC strongly recommends that email communications be sent from and received via my ISU sponsored email account only and not auto-forward to an unsecured or third- party system.
4. For my convenience, TSHC also offers me a choice of receiving text messages to remind me of upcoming appointments and/or care coordination activities. TSHC limits information sent via text message to the minimum necessary.
5. I also understand that:
    - TSHC considers all patient medical information as confidential. However, email users should never consider electronic communications to be entirely private or secure.
    - TSHC strongly recommends that email communications be sent from and received via my ISU sponsored email account.
    - I should NOT use email for any emergency situation or when an immediate or urgent response is needed.
    - I have the choice to "opt out" of receiving communications from TSHC via email and/or text.

Further, I agree and understand that:

1. I may be contacted for additional information regarding my health care or insurance coverage by TSHC.
2. I am responsible for, and agree to pay, all charges that exceed or are not covered by university student health fees and/or my health insurance coverage.
3. I understand that the unpaid medical charges will be transferred to the university billing system (U-Bill) and I may be contacted by ISU Accounts Receivable, if the charges remain unpaid.
4. I intend this consent to remain in effect, so long as I am a student at ISU. However, I understand I may withdraw this consent in writing.
5. My withdrawal will not be effective for actions already taken (or in the process of being taken) by TSHC.
6. If I am under age 18, my parent or legal representative must sign this form consenting to medical care on my behalf with the exception of the following types of healthcare that by Iowa law I am able to consent for myself:
    - Emergency Care
    - Contraceptive Services
    - HIV/AIDS Care
    - Sexually Transmitted Infection prevention, diagnosis & treatment
    - Substance Abuse Treatment
    - Tobacco Cessation
    - Victim Medical and Mental Health Services

Patient's Printed Name

Today's Date (MM/DD/YYYY)

Patient's Date of Birth (MM/DD/YYYY)

Patient's University ID#

Signature of Patient

Signature of Legal Representative (if patient under age 18) and Relation to Patient (e.g., Mother, Father, Guardian, etc.)

☐ **Terms of Acceptance and Signature:** I accept and understand that by typing my name here, I am signing this Agreement electronically. I agree and understand that my electronic signature is the legal equivalent of my handwritten signature and that I am legally bound by the terms contained in this document.

or email to SHCReco@iastate.edu