



**Student Health Clinic and Counseling Services**

! 05 2 8 2 18

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student ID: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Billing Address: \_\_\_\_\_

**Insurance Information:**

Company Name: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

I agree SDSU Student Health Clinic and Counseling Services will bill and provide necessary health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers will make uncoordinated payments.

-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 is the legal equivalent of your manual signature. You further accept that you are legally bound by this terms and conditions.**

\*Signature: \_\_\_\_\_ Date \_\_\_\_\_

I (the member/patient or if a minor, guardian of the member as listed above) **acknowledge** that the SDSU Student Health Clinic . 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 \_\_\_\_\_