**Acknowledgement of Privacy Notice and Financial Disclaimer**

Please initial each statement to signify your understanding of each notice:

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| \_\_\_\_\_\_\_ | I have received a copy of the Notice of Protected Health Information Practices to read detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of this document and have been offered a copy of this document for my records. I understand that if I can request a copy of this Notice at any time by asking staff or checking the HCSW website.  |
| \_\_\_\_\_\_\_ | I grant permission for treatment for today’s visit and all future visits. |
| \_\_\_\_\_\_\_ | Upon submission of my insurance information, I give Health, Counseling and Student Wellness (HCSW) permission to bill my insurance for today’s visit and all future visits. It is my responsibility to be familiar with my own insurance coverage as well as any policy exclusions. |
| \_\_\_\_\_\_\_ | I understand that HCSW is in network with several insurance plans; however, I understand that HCSW does not bill Medicare or Medicaid. |
| \_\_\_\_\_\_\_ | At the time of service, I will be responsible for paying any applicable co-pay or deductible per my insurance plan. |
| \_\_\_\_\_\_\_ | I hereby authorize HCSW to furnish information to my insurance carrier(s) concerning my illness, condition and treatment, and I hereby irrevocably assign to HCSW all payments made by my insurance carrier(s) for services rendered. |
| \_\_\_\_\_\_\_ | I understand that I am ultimately responsible for payment for all services, with or without insurance, and that understanding my plan coverage is my responsibility. |
| \_\_\_\_\_\_\_ | I understand that I will be subject to a **$15 fee** for missed appointments, late cancellations (less than 24 hours’ notice) or late arrivals for an appointment. |
| \_\_\_\_\_\_\_ | I understand that outstanding charges past due for 30 days will be billed to my Bursar account. HCSW will send out all outstanding bills via email to my NKU email address. I understand that email is not a 100% secure means of communication and that no clinical information will be sent with my bill. Only outstanding balances will be sent to my NKU email address. [ ] I GIVE PERMISSION for NKU Health, Counseling, and Student Wellness to send a statement of outstanding charges to my NKU email address. I acknowledge that no clinical information is included in the email. [ ] I DO NOT GIVE PERMISSION for NKU Health, Counseling, and Student Wellness to send my outstanding balance statement to my email address. I acknowledge that my balance will automatically be put on my Bursar account after 30 days with no notice via email.  |

My signature below verifies that I understand the above information:

Patient Printed Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature: **Student type signature here.**  Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Parent/Guardian Signature (if applicable): **parent type name if under 18.** Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**