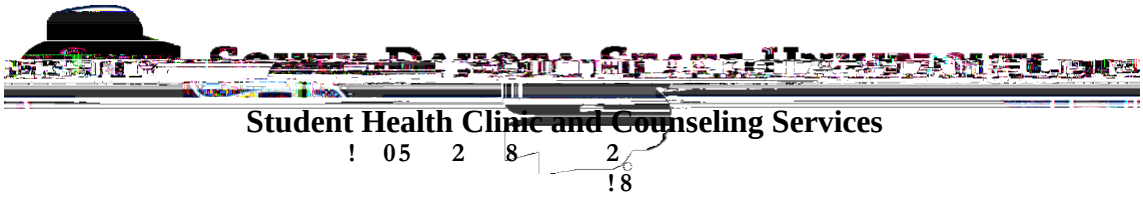

Student Health Clinic and Counseling Services

! 05 2 8 2
!8

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 urance polic amoun

-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 s 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_____