WESTERN MICHIGAN UNIVERSITY
UNIFIED CLINICS - PATIENT CONSENT SHEET

Patient Name _____ Date of Birth _____

Patient Address _____ City/State/Zip _____

Home/Cell Phone (  ) _____ Work Phone (  ) _____

Email _____

Are you of Hispanic, Latino, or of Spanish origin? *Yes* ☐ *No* ☐

How would you describe yourself? (please circle one)

American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ☐

I choose to receive communications from Unified Clinics by text or email at the number or address stated above, including but not limited to, communications about appointments, treatment, and payment. I understand that such emails and texts may not be secure, and there is a risk that they may be read by a third party. Please check one: *Yes* ☐ *No* ☐

## MEDICAL TREATMENT CONSENT AND AUTHORIZATION TO BILL

I authorize treatment and the release of any medical or other information necessary to process my claims to my insurance carrier. I authorize payment of my medical benefits to WMU Unified Clinics. I understand payment is my responsibility for all charges regardless of insurance coverage, and agree to pay any amount not covered by my insurance.

## ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time. I may obtain a revised copy of the Notice by calling (269) 387-7001, on the University's website at www.wmich.edu, on our website at www.wmich.edu/unifiedclinics, or by requesting one at the University's offices.

_____
**Date**

_____ _____
**Patient or personal representative Signature** **Print or Type Name**