Student Health Services
MINNESOTA STATE UNIVERSITY, MANKATO

Patient Registration Form

Name: _____
Last First Middle Initial

___Female ___Male ___Transgender ___Not listed **Tech ID: _____**

Cell Phone: (_____)_____ **Date of Birth: _____/_____/_____**
Month Day Year

School Address:_____
Street City State Zip

Home Address:_____
Street City State Zip

IN CASE OF EMERGENCY: PERSON TO BE NOTIFIED

Name:_____Relationship:_____Phone: (_____)_____

Consent and Authorization for Release: I consent to the release by Minnesota State University, Mankato Student Health Services (SHS) of health records, including medical and other information about me to the following: to an insurer, third party payor, third party administrator or other entity providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews, in accordance with Minnesota Law.

Electronic Communication: I agree to allow SHS to use electronic communication. This communication will not include details about my personal health records.

Payment Responsibility: Except as specifically agreed to in writing by SHS with me or as prohibited by SHS contract with a third-party payor or applicable law, I agree that I am responsible to pay SHS for all services furnished to me by SHS, including but not limited to, charges that for any reason are not paid in full by my insurance, government program benefits, or other third-party payors. I am aware that *failure to show up for an appointment, without notification, may result in a fee not covered by insurance*.

***I have provided a copy of my current medical / pharmacy insurance card(s) to the front desk at Student Health Services.**

Privacy Practices: I acknowledge that I have been presented with the Notice of Privacy Practices. To view an electronic version of this document, visit www.mnsu.edu/shs/confidentiality.html. I can request a paper copy during my visit or by calling 507-389-6276.

Health Care Directive: I acknowledge that I have the right to designate someone to make health care decisions for me and that this requires a legal document known as a Health Care Directive. Information regarding Health Care Directives is available to me during my visit or at www.mnsu.edu/shs/forms.html.

I understand that I have the right to revoke the authorizations on this form at any time by notifying SHS in writing to Minnesota State University, Mankato Student Health Services, 21 Carkoski Commons, Mankato, MN 56001 or fax at 507-389-5787.
SHS cannot prevent re-disclosure of your information by the person or organization who receives your records.

ATTENTION: By signing, I agree that I understand and accept the terms on this form.

Signature:_____ Date:_____
Patient Signature; legal guardian if patient is under 18 years of age (list relationship)

This authorization lasts for one year.