LAFENE HEALTH CENTER
Kansas State University, 1105 Sunset Ave, Manhattan KS 66502

Telephone: (785)532-6544
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TREATMENT AGREEMENT

FILL OUT THIS FORM COMPLETELY. PLEASE PRINT LEGIBLY.
Completion of this form is required before receiving non-urgent care at Lafene Health Center.

ACKNOWLEDGEMENT OF PATIENT RESPONSIBILITY:

Last Name:	First Name:	Middle Initial:
Wildcat ID #:	Date of Birth:	

1.	I consent to the use or disclosure of my protected health information by Lafene Health Center (LHC) staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations including filing insurance claims.
2.	I consent to allowing LHC to obtain electronic images of my condition, or symptoms thereof, for the purpose of diagnosis or treatment, tracking my progress, or for internal quality assurance purposes.
3.	I understand that I have the right to request a restriction or limitation on how and to whom my protected health information is used or disclosed for the above purposes. LHC is not required to agree to such a request, but if agreed upon, the Health Center will comply unless the information is needed to provide me emergency treatment.
4.	I understand that I must present my **medical insurance information to Lafene on or before the date of service** or Lafene may not submit my charges to insurance for my medical services. I also understand that I must present my **prescription insurance directly to the Pharmacy on the date of service** in order for the pharmacy to file my claim for me.
5.	I understand that LHC does not contract with all insurance companies and it is my responsibility to know if my insurance plan provides coverage for these services or requires a referral or pre-approval for such services.
6.	I understand that if I do not want my insurance billed for specific services, I must notify the Health Center Check-In area the same day of service.
7.	I understand that I am financially responsible to LHC for any charges, copays, and deductibles not covered by my insurance/health plan. And, I understand that if I do not pay my bill within 60 days of my date of service, my overdue account will have a hold put on it from the University, preventing me from receiving transcripts.
8.	**I understand that LHC is not a contracting provider for and cannot bill KanCare, Medicare, Medicaid, or Healthwave.** If I have these types of government health benefits, I am responsible for paying all Lafene charges, and it is my responsibility to seek reimbursement from these programs.
9.	I further authorize LHC to file any mandatory reporting to the State as required by State law.
10.	I give my consent for immunization information to be released to the Kansas Immunization Program for the purpose of assessment and reporting.
11.	I understand if I make an appointment and then fail to keep the appointment without notifying LHC, I will be assessed a failed appointment charge.

SIGNATURES:

I hereby grant permission to Lafene Health Center to carry out necessary medical treatment of the above patient.	
Patient Signature:	Date:
IF PATIENT IS UNDER 16 YEARS OF AGE, SIGNATURE OF PARENT/GUARDIAN AND PATIENT IS REQUIRED.	
Parent Signature:	Date: