WILLIAM PATERSON UNIVERSITY
COUNSELING, HEALTH & WELLNESS CENTER
OVERLOOK SOUTH

(973)-720-2360 · (973)-720-2257 · FAX: (973)-720-2632
300 POMPTON ROAD · WAYNE, NEW JERSEY 07470-2103 · WWW.WPUNJ.EDU

MEDICAL

CONSENT FOR TREATMENT & INSURANCE AUTHORIZATION

A) CONSENT FOR MEDICAL TREATMENT

I hereby consent to medical treatment as deemed necessary by The Counseling Health and Wellness Center (CHWC) providers, including routine health examinations, preventative measures, laboratory tests, administration of medications, any other diagnostic or therapeutic treatments, first aid and necessary referral to outside healthcare providers. My signature below indicates that I have had the chance to read the **NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES** AT CHWC. I understand that I may request a printed copy of this policy at any time.

B) ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

1) I understand that CHWC does not contract with all health insurers and it is my responsibility to know if my health insurance provides coverage for CHWC services or requires a referral or pre-approval for such services.
2) I understand that I am financially responsible to CHWC for any co-pays, deductibles and/or co-insurance not covered by my health insurance.
3) I understand that certain insurance plans (including but not limited to HMOs and EPOs) designate specific providers for my health care, and will not pay Counseling, Health and Wellness Center for services rendered. I understand the policy of my plan; I choose to receive services at CHWC, and I am aware that I am financially responsible to pay for the services that I receive at CHWC.

C) **INSURANCE AUTHORIZATION (If your health insurance contracts with CHWC)** I understand that Medical
1) Healthcare Solutions (MHS) is contracted with CHWC to provide medical billing services.
2) I authorize MHS to apply for benefits on my behalf for the medical services rendered. I certify that the health insurance information I have provided to CHWC is true and accurate. I understand that if my health insurance information or coverage changes, I must notify CHWC
3) If I do not want my health insurance to be billed for the care rendered by CHWC, I understand that it is my obligation to notify the CHWC front office staff at the end of my visit and to complete a Self-Pay Request form. If I make this election, I understand that I will be responsible for payment in full for all charges for my care from CHWC.
4) I understand that MHS and/or my health insurance company may request and receive medical information about me if CHWC files a claim on my behalf. I also understand that the subscriber to my health insurance will be notified by my health insurer of the nature of these claims filed on my behalf. The subscriber is the person who is the primary policy holder for my health insurance (for example, my parent or spouse).
5) I understand that I may address any questions concerning my charges, coverage, billing or payments, to MHS at 1800-762-9800.

CONSENT TO A, B, C: **Student's Signature** _____

CONSENT FOR MHS TO DISCUSS CLAIM INFORMATION/CHARGES WITH MY SUBSCRIBER/INSURANCE POLICY HOLDER

O O
YES NO

I authorize MHS staff to discuss insurance claim information (which may include diagnosis and treatment information) with the subscriber, the person named as the primary policy holder on my health insurance, and to my health insurance for a claim filed on my behalf. I understand that I have the right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing to The Counseling Health and Wellness Center, 300 Pompton Road, Wayne, NJ 07470. Unless revoked, this consent will be valid for the remainder of the current calendar

Student's Name _____ Student ID# 855_____
(Please Print)

Student's Signature _____ Date ____/_____/_____

Parent/Guardian's Signature _____ Date ____/_____/_____
(Required only if the student is 17 years old or younger)

FOR OFFICE USE ONLY

Witness Signature _____ Date: _____

We attempted to obtain written consent for treatment and release but consent could not be obtained because:
_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the consent.
_____ An emergency situation prevented us from obtaining consent
_____ Other (Please Specify) _____

Name/Signature of Office Staff: _____