



**University
Wellness Center**

660.562.1348 office
660.562.1857 fax

University Wellness Center

Consent to Receive Treatment; Acknowledgement of Notice of Privacy Practices

I hereby consent to receive medical and/or mental health care from University Wellness Service, or from the professional staff of any other student healthcare facility located on campus. I also authorize such treatment, x-rays or other diagnostic studies and assessments as, in the judgment of the attending professional, may reasonably be necessary to assist me, and/or preserve and protect my health.

I understand that in addition to Wellness Services staff, I may be assisted by Medical, Counseling, or Nursing students who are learning more about the profession, and are shadowing/assisting Wellness Services in a professional manner.

I understand that I am responsible for all charges billed to me that are not otherwise covered by northwest Missouri State University's student designated fee, or my health insurance organization.

I understand that Wellness Services' medical and mental health professionals may privately and securely discuss certain aspects of my health and wellness, in order to provide quality comprehensive care.

I also acknowledge receipt of Wellness Services' Notice of Privacy Practices, which is available to me at:

<https://www.nwmissouri.edu/wellness/PDF/NoticeOfPrivacyPractices.pdf>

I have reviewed this notice, which describes how medical information about me may be used and disclosed, as well as how I can access my protected health information.

Student Signature: _____

919#: _____ Date: _____