Wellness Center
Winans Hall
201 Mullica Hill Road
Glassboro, NJ 08028-1701
Phone: 856-256-4333
Fax: 856-256-4427

Authorization of Treatment

CLIENT NAME _____ DATE OF BIRTH _____

STUDENT ID # _____ ENTRANCE DATE _____

ADDRESS _____

CITY _____

STATE, ZIP CODE _____ PHONE _____

Authorization of treatment statement

I hereby authorize the Rowan University Wellness Center staff and physicians to provide health care evaluations, treatment and other medical services as necessary. I certify, to the best of my knowledge, that the information provided in my health record is complete and accurate.

In case of emergency, I authorize the Wellness Center to secure emergency medical evaluation, treatment and/or surgery at a hospital if such treatment is deemed necessary. I authorize Rowan University Wellness staff and physicians to share any medical information with hospital or emergency medical personnel in the case of an emergency or subsequent treatment. I understand that in the event of serious illness or injury, my parent(s) or legal guardian(s) may be notified at the discretion of the Wellness Center staff.

I understand that the Wellness Center staff, including Student Health Services nursing and medical providers, Counseling and Psychological Services counselors and psychiatry providers, and Alcohol and Other Drug Services providers have access to medical and mental health information, with the exception of psychotherapy notes, as it relates to my health care services, and I understand that any/all of these providers retain the privilege to consult with one another regarding my treatment and/or training purposes. I understand that if I participate in group counseling or health education that I, along with fellow members of that group, will be expected to commit to maintaining the confidentiality of that group.

I understand that my insurance company and I will be billed for services received at the Wellness Center. Any co-pays that are not paid at the time of the visit, any deductibles or other remaining balances will be subsequently invoiced. I understand that I will receive one verbal reminder at the time of visit that payment is due. I understand that I will receive email reminders and/or additional letters addressed to me at my home address on file for any co-pays not paid at time of service, deductibles, or other open balances. I understand that in most instances, an Explanation of Benefits (EOB) forms, which explains detailed insurance coverage related to the services received, will be sent from my insurance carrier to the primary card holder which may be my parent(s).

This authorization will remain in effect as long as I am a student at Rowan University and replaces any previous authorization(s).

_____ _____

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO CLIENT DATE