Patient Information:

Name: ____
Billing Address: ____
City: ____________________________________ State ____________ Zip ______________
Cell: ____________________________________ Home _______________________________

DOB: _____________ Male ______ Female______
Social Security Number: ___________________ Email address: _________________________

Insurance Information: We will photocopy the card if available, if not, please fill out the information below:

Primary Insurance:
Name: ______________________________
ID # ________________________________
Group # _____________________________
Effective Date: ________________________
Policy Holder:____________________________
PCP:__________________________________

Secondary Insurance:
Name: ____________________________
ID # ______________________________
Group # ___________________________
Effective Date: ______________________
Policy Holder:____________________________

Emergency Contact:
Relationship: _________________________
Name: ____
Address: ____
City: __________________________________ State ____________ Zip _______________
Cell: __________________________________ Home _______________________________

If no insurance has been given at the time of service, bills will be sent to the billing address above. We are not responsible for statements sent to your home address from your insurance company or outside facilities.

I have read and understand the above information.
Signature _____________________________________ Date: ______________________

Consent for the Treatment of Minors

Maine law requires that parental permission be obtained for medical treatment of minors except when certain exceptions apply. The law defines "minor" as a person under the age of 18 years.

Student Name ____ **Date of Birth** _____________________________

Parent/Guardian Consent:

I hereby authorize UNE or its authorized representatives to provide such physical and/or mental health treatment, as required, for the student named above. Such care shall include but not be limited to diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, any necessary medical treatment, and mental health counseling. For surgical procedures or more extensive medical care, reasonable attempts will be made to contact me before such care is initiated. Failure to do so should not prevent UNE or its authorized representatives from providing such emergency treatment as may be necessary for the best interests of the student.

I understand that the student's contact with individuals providing physical and mental health services at UNE are held in confidence, but that such confidentiality may be breached in certain circumstances. Including but not limited to the event that the student's safety or that of another person is in imminent danger, in accordance with state and federal laws and regulations.

I further understand and agree that this authorization will be in effect until the student reaches the age of 18 years. By signing this authorization form, I acknowledge that I have read and understand this consent.

____________________________________ ________________________________ _______________
Signature of Parent/Guardian **Printed Name of Parent/Guardian** **Date**