

TO: Welcome New Wartburg Knight Student
FROM: Noah Campus Health Clinic
RE: Your Health Forms

The Health Clinic staff welcomes you to Wartburg, and we offer our support in any way possible during your years here. If you have a special need or require assistance with a medical problem, please do not hesitate to contact Noah Campus Health Clinic at 319-352-8436 or the Student Life Office at 319-352-8260. The Noah Campus Clinic is located in the “W” for your convenience. Other off-campus clinics are available to you.

Please complete the enclosed health forms as soon as possible. All forms are due no later than **July 15** of this year. These health forms are required of all first year students. Student athletes must submit these forms prior to participating in any intercollegiate athletics. Medical forms are strictly confidential and are used by the Noah Campus Health Clinic and Wartburg College to provide care.

Based on The Centers for Disease Control and the American College Health Association guidelines, Wartburg requires all enrolled students to have **proof of two MMR (measles, mumps, rubella) immunizations, TB, Varicella (chicken pox), Tetanus/Diphtheria, and Polio Boosters**. Proof of natural immunity through documentation of physician-diagnosed disease or a positive serum titer may be substituted in place of vaccination documentation. Although not required, it is recommended that students be vaccinated against hepatitis B, hepatitis A, and meningitis. Please consult your clinician regarding these vaccines. Subsequent course registration may be withheld and an additional charge will be imposed for any student who comes to college without documented proof of proper immunizations.

CHECKLIST

- () **New Patient Information Form**
- () **Health History and Shared Information Form** – This form should be completed by the student before seeing a physician to complete the Wartburg Physical Exam form.
- () **Wartburg Physical Exam Form** – A physician must have performed an exam within the past year, one year prior to the beginning of your first term at Wartburg.
- () **Copy of current insurance card** – Include a clear copy of your insurance card (front & back) and make a copy for yourself. Check to see that your insurance covers you while away at college.
- () **Copy of current prescription drug card** – Include a clear copy of your prescription drug card (front & back) and make a copy for yourself. Check to see that your drug card covers you while away at college.
- () Return completed forms in enclosed envelope.

NOAH CAMPUS HEALTH CLINIC

a department of Waverly Health Center

New Patient Information

Date: _____

Patient's Name: _____

Sex: Male Female Race: _____ Age: _____

Marital Status: Single Married Divorced Widowed

Birth Date: _____ Social Security #: _____

Address: _____

Home Phone: _____ Living Will: Yes No

Cell Phone: _____ Does the hospital have a copy? Yes No

Insurance Information:

Primary Insurance Company Name: _____

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Policy Holder's Employer: _____ Policy Telephone #: _____

Policy Numbers: _____ Group Numbers: _____

Secondary Insurance Company Name: _____

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Policy Holder's Employer: _____ Policy Telephone #: _____

Policy Numbers: _____ Group Numbers: _____

Guarantor/Person Responsible for Charges

Name: _____ Phone: _____

Address: _____

Person to Contact in an Emergency (include relationship)

Name: _____ Phone: _____

Name: _____ Phone: _____

Family or Other Person(s) whom we may release your medical information to:

Conditions of Admissions

Medical Treatment—I permit my health care provider, the hospital and its employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, examinations, and medical treatment.

Practice of Medicine—I understand medicine is not an exact science and that diagnosis and treatment may involve risks. I realize no guarantees have been made to me as to results of examination or treatment at Noah Campus Health Clinic.

Special Procedures/Surgery Consent—I am aware, except in emergency situations, that any substantial procedures/surgery shall be explained to my satisfaction by the health care provider or other health professionals. I have the right to consent or refuse consent to such procedures. If the procedure is of an experimental nature, I will have full knowledge.

Ambulance Transfer for Medicare Patients—I understand that if I am required to be transferred to another facility by ambulance, Medicare will pay for transfer to the nearest hospital which is able to provide the services I need. If I am transferred further away, I will be responsible to pay for the portion of the ambulance charges that are not covered by Medicare.

Medical Staff and Student Participation—I understand that the health care providers serving patients including: radiologists, pathologists, anesthesiologists, emergency physicians, and the like, are not hospital employees but independent contractors and may be billing separately. I realize that among those attending patients at this clinic are health care personnel in training, who unless requested otherwise may be present during patient care as a part of their education. Observation, pictures, or closed circuit monitoring of patient care may be used for educational purposes unless a patient requests otherwise.

Insurance and Payment Data—Patients are responsible for all charges incurred at Noah Campus Health Clinic. Your health insurance will be considered the primary insurer. Treatments, procedures, and other needed services and supplies will be submitted to your health insurance company with your signed consent. The guarantor, normally a parent or guardian for students, will receive an itemized bill from Noah Campus Health Clinic/Waverly Health Center for co-payments, deductibles, and other charges. A copy of your insurance card is required at check-in. If you belong to an HMO, be aware of restrictions and limitations for medical or pharmaceutical services outside of your HMO territory.

Services performed by Physician Assistants may not be covered by some insurance plans. Please check with your insurance company to verify coverage.

Assignment of Insurance Benefits/Financial Agreement—I authorize payment of my insurance benefits directly to Noah Campus Health Clinic for the services provided during my clinic visits. I understand I am financially responsible to Noah Campus Health Clinic for all charges whether they are covered by my insurance or not. I understand that if my charges are not paid in full within three billing cycles, my outstanding charges will be turned over to Wartburg for collection which may include applying the unpaid balances to my Wartburg student bill.

Acknowledgment of Patient Rights

_____ I acknowledge that I have been made aware of The Patient Bill of Rights and that I may receive a copy upon
initials request.

Confidential Sharing Agreement and Consent for Treatment—Noah Campus Health Clinic assures that medical information will be regarded as confidential and shared only as necessary for the patient’s immediate safety. The Clinic will not release medical information to parents unless the student signs a separate release of information specific to each illness/incident. If a serious illness or accident should occur, every effort will be made to contact the individual listed as emergency contact. However, in the event that delay in medical or surgical treatment may be detrimental to the health of the student, authorization for consultation and treatment by area physicians is requested. Noah Campus Health Clinic recognizes the importance of cooperating with the student’s family physician, clinic, or hospital in providing health care. In order to secure or exchange health information, it is necessary to have the permission of the student. On occasion, information regarding physical or mental health status of a student may be shared with the vice president for student life or counseling staff if sharing that information would benefit the student. No information will be provided to faculty or work study supervisors without specific consent of the student. Permission is hereby granted to share health information with my family physician, clinic, hospital, vice president for student life, or counseling staff if this information would be beneficial to my health.

This form has been explained to me and I understand its contents.

Signature of patient

Date

Signature of parent/guardian (if patient is under age 18)

Date

Patient did not sign admission for the following reason:

- Minor Physically Unable Has Legal Guardian