STEPHEN F. AUSTIN STATE UNIVERSITY
Health and Wellness Hub

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Health Services with Stephen F. Austin State University as your healthcare provider. We are committed to providing you the highest quality healthcare. Please read, initial, and sign this form to acknowledge your understanding of our patient financial policies.

I acknowledge the following:

_____ Health Services will bill my insurance on my behalf. I am required to provide the most current and updated information regarding my insurance **every visit**.

_____ I am financially responsible for all billed services associated with treatment received from Health Services, including any fees which are not covered by my health insurance.

_____ If payment in full is not received within two weeks of notification of responsibility, a hold will be placed on my student account. I understand this hold will prevent me from registering, adding, or dropping classes, as well as receiving an official transcript.

_____In accordance with University Policy 3.28, failure to satisfy any outstanding balance may result in collection efforts being taken against me, including but not limited to, referral to a collection agency or filing suit.

I have read, understand, and agree to the provisions of the Patient Financial Responsibilities Form.

_____ _____
Printed Name Student ID

_____ _____
Signature of Patient or Guardian Date