For patients under the age of eighteen (18) to be seen by clinical and counseling employees at Sindecuse Health Center, this form must be signed. Health Center staff make every effort to contact you in the event of an emergency or serious illness.

I hereby authorize staff of Sindecuse Health Center at Western Michigan University to administer treatment to my son or daughter. This authorization is effective from the date of signature until the patient is of legal age or ineligible to use the facility’s services.

I hereby authorize staff of Sindecuse Health Center at Western Michigan University to administer medical treatment to my son or daughter. This authorization is effective from the date of signature until the patient is of legal age or ineligible to use the facility’s services.

MINOR’S NAME (PRINT)  WIN (WMU IDENTIFICATION NUMBER)

x

PARENT OR GUARDIAN’S SIGNATURE  DATE

PARENT OR GUARDIAN’S NAME (PRINT)  HOME PHONE #

MOBILE PHONE #  WORK PHONE #
### Patient Insurance Information

**THIS FORM MUST BE COMPLETED FOR SINDECUSE HEALTH CENTER TO BILL YOUR INSURANCE.**

**PATIENT**

- **name (print)**
- **date of birth (mm/dd/yy)**
- **local address**
- **city**

**POLICY HOLDER 1**

- **name (print)**
- **date of birth (mm/dd/yy)**
- **local address**
- **city**
- **employer**

**INSURANCE 1**

- **insurance company**
- **claim submission address**
- **contract/policy number**

**POLICY HOLDER 2**

- **name (print)**
- **date of birth (mm/dd/yy)**
- **local address**
- **city**
- **employer**

**INSURANCE 2**

- **insurance company**
- **claim submission address**
- **contract/policy number**

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**I authorize Sindecuse Health Center to furnish information to my insurance carrier concerning my illness and treatments.**

- **x**

**MEDICARE RECIPIENT**

I request that payment of authorized Medicare benefits be made on my behalf for services furnished me by Sindecuse Health Center. I authorize them to release medical information to the Center for Medicare and Medicaid Services or its agents any information needed to determine these benefits or the benefits payable for related services.

- **x**

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Mail this form to: Sindecuse Health Center, Western Michigan University, 1903 W Michigan Ave, Kalamazoo, MI 49008-5446.

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269 387 3287
269 387 3204 fax