NKN STUDENT HEALTH & WELLNESS CENTER

24705 US-101, Rockaway Beach, OR 97136 | Mailing Address: PO Box 176, Wheeler, OR 97147
Telephone: 503-355-3500 | Fax: 844-720-1901

Rinehart Clinic is the medical sponsor for NKN Student Health & Wellness Center and operates according to the guidelines set forth by Oregon Law (Oregon Revised Statutes: 109.610, 109.640, 109.675, 109.680). All services will be provided by the Rinehart Clinic health care team.

CONSENT TO TREAT - STUDENT

I understand that:

- No patient will be turned away if unable to pay for the services provided.
- Each patient or their appropriate patient representative has the right to refuse consent for treatment.
- Unless there are emergency circumstances, no substantial procedure will be performed unless there is a discussion of the treatment with the health care team and the patient or patient representative.
- Patients at any age may sign their own consent to access reproductive health services. Patients age 14 and older may sign their own consent to access mental health or treatment for chemical dependency. Patients age 15 and older may sign their own consent for medical treatment.
- Patients under 15 years of age need a parent or guardian's signature for all health care services, except as noted above.

_____ _____ _____

Signature of Patient (or Guardian) Printed Name Date

INSURANCE AND PAYMENT

- I understand as a student, I am not responsible for any out-of-pocket expenses.
- I understand that if I have insurance, I am responsible for the terms and conditions of my individual insurance plan.
- I authorize my insurance benefits be paid directly to Rinehart Clinic.
- I authorize Rinehart Clinic to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.
- I understand that Rinehart Clinic has a sliding fee scale that may provide a discount based on household income.
- I understand that Rinehart Clinic's Enrollment Navigators can help me to determine my eligibility for state insurance plans or other financial assistance. I will ask for financial assistance if necessary.

_____ _____ _____

Signature of Responsible Party Printed Name Date