SAINT XAVIER UNIVERSITY HEALTH CENTER INTAKE & CONSENT

PATIENT FIRST NAME		**PATIENT LAST NAME**	
PREFERRED NAME	**GENDER**	**DATE OF BIRTH**	
PERMANENT STREET ADDRESS			
CITY	**STATE**	**ZIP CODE**	
CELL PHONE:	**CAN WE LEAVE A MESSAGE? Yes or No**	**ALTERNATE PHONE:**	**CAN WE LEAVE A MESSAGE? Yes or No**
E-MAIL ADDRESS:			
EMERGENCY CONTACT NAME & RELATIONSHIP (if here with minor child, please give parent name/relationship):		**EMERGENCY CONTACT NUMBER**	
PREFERRED PHARMACY FOR E-PRESCRIBING **____ WALGREENS** **____ CVS** **____ WALMART** **____ Mariano's** **____ JEWEL OSCO** **OTHER:_____**		**ADDRESS OR INTERSECTION/ CITY AND ZIP CODE OF PHARMACY:**	

CONSENT FOR TREATMENT	**INITIAL:**	**By initialing I acknowledge that I was presented with a copy of the SXU Consent for Treatment. My signature below renders my consent.**
CONSENT FOR E-PRESCRIBING	**INITIAL:**	**By initialing I acknowledge that I was presented with a copy of the Consent for E-Prescribing Policy. My signature below renders my consent.**
CONSENT TO ACCESS RX HISTORY	**INITIAL:**	**By initialing I acknowledge that I was presented with a copy of the Consent to Access Prescription History Policy. My signature below renders my consent.**
I-CARE	**INITIAL:**	**By initialing I acknowledge that I was presented with a copy of the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE). My signature below renders my consent.**
GUARANTEE OF PAYMENT	**INITIAL:**	**By initialing I acknowledge that I was presented with a copy of the Guarantee of Payment Policy. My signature below renders my consent.**
PRIVACY PRACTICES	**INITIAL:**	**By initialing I acknowledge that I was presented with a copy of the Privacy Practices Policy. My signature below renders my consent.**
Only complete the following if SXU is to submit an insurance claim on your behalf:		
ASSIGNMENT OF INSURANCE BENEFITS	**INITIAL:**	**By initialing I acknowledge that I was presented with a copy of the Assignment of Insurance Benefits Policy. My signature below renders my consent.**

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF <18 YEARS OLD): _____

IF PARENT/GUARDIAN, RELATIONSHIP TO PATIENT: _____

INDIVIDUAL COMPLETING THIS FORM (PRINT NAME OR WRITE *SELF*): _____

DATE COMPLETED: _____ **Whom may we thank for referring you? _____**