UNIVERSITY OF OREGON

Parent/Guardian Form
Assignment of Benefits & Consent for Insurance Billing
In the Case of a Minor Student

The University Health Center provides courtesy billing for some health insurance plans. To ensure accurate billing, we must receive correct insurance information and timely updates of any and all changes to your insurance.

Student's Name:_____ Date of Birth:_____ UO ID:_____

I authorize for any insurance benefits owed in the course of care for my child (listed above) to be paid directly to the University of Oregon, University Health Center (UHC) and authorize UHC and/or my insurance carrier to release any information required for processing a claim. I understand that it is my responsibility to know my child's insurance coverage and benefits. I understand that it is my responsibility to immediately notify the UHC in the event of a change in insurance coverage.

I understand that I am ultimately responsible for the payment of any and all UHC charges, including balances not paid by my insurance carrier. I understand the balances will be transferred to my child's University of Oregon student account.

If covered by Oregon Medicaid programs such as the Oregon Health Plan (OHP) or Oregon Contraceptive Care (CCARE), I authorize UHC to bill any identified private health insurance before billing OHP/CCARE unless I have specifically requested, for reasons of confidentiality, that private insurance not be billed. In this situation, I understand that I will be responsible for the full cost of services and goods rendered.

I hereby consent to the University of Oregon, including any of its school officials, releasing my educational records (which refer to medical records in this instance) as stated below:

Specific records to be released: Records relating to:

(1) billing third parties for health care services provided them; or
(2) paying for health care services provided to them.

Purpose for the release: To bill for or to pay for health care services provided to them.

Party or class of parties to whom the records are being released:

(1) Health care providers who have provided treatment to them;
(2) insurance companies that are obligated to pay for health care services provided to them; and
(3) other third parties that process payment for health care services provided to them.

By signing below, I acknowledge that I have read and understood and agree with the contents of this document and that the information is accurate to the best of my knowledge.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date:_____