UND School of Medicine & Health Sciences
UNIVERSITY OF NORTH DAKOTA
DEPARTMENT OF SPORTS MEDICINE

CENTER FOR SPORTS MEDICINE
HYSLOP SPORTS CENTER RM 144
2751 2ND AVE N STOP 9013
GRAND FORKS ND 58202.9013
P: 701.777.4845 | F: 701.777.2536

Update Patient Information

PLEASE UPDATE YOUR INFORMATION:

Name: _____ ,_____ ,_ _____
Last *First* *M.I.*

ADDRESS:
Primary Address: _____ _____, _____ _____
City *State* *Zip Code*

CONTACT INFORMATION:
Cell Phone: _____ Text messaging authorization: Yes ☐ No ☐

Email: _____ Email authorization: Yes ☐ No ☐

Note: Email is not a secure transmission route. Therefore, we ask you to be cautious of sending sensitive information via email or electronic messaging.

INSURANCE Subscriber Information: **Attach a copy of Insurance Card - Front & Back of Card**

Name: _____ Date of Birth: ____/____/____
Last First M.I.

Address: _____ _____, _____ _____
City *State* *Zip Code*

Phone Number:_____

INSURANCE CARRIER INFORMATION:
Primary Insurance Carrier: _____ ID#: _____ GROUP#: _____

Address: _____ _____, _____ _____
City *State* *Zip Code*

Phone Number:_____

Secondary Insurance Carrier: _____ ID#: _____ GROUP#: _____

Phone Number:_____

INSURANCE AUTHORIZATION

I hereby authorize UND Center for Sports Medicine to release information acquired during/after my treatment to my insurance company for billing purposes. This includes all Travel, Canadian, and out of country policies. I agree that my insurance company will make payment directly to UND Center for Sports Medicine. If your insurance company reimburses you directly, it is your responsibility to submit payment to UND Center for Sports Medicine. I understand, I am financially responsible for all charges not covered by my insurance including but not limited to, copays, deductibles, coinsurance, uncovered treatment, etc. This document is a copy of the original and will be treated the same as an original document.

Student/FERPA Privacy Practices

I acknowledge that I have received a written copy of the University of North Dakota Center for Sports Medicine Notice of Patient Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Nonstudent/HIPAA Privacy Practices

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_____ **Date:**_____/_____/_____
Signature of Patient or Legal Guardian