

All students please complete important insurance information.

Local physicians will generally make an appointment for students on the day requested by Student Health Services. Full or co-pay payments are due at the time of the visit. Specific insurance information from you and your provider will assist in making the appointment with the appropriate physician or local clinic who in turn may file the charges for the visit to the student's insurance provider.

Please list physicians and hospitals in Searcy that are mandated by your insurance company. (If unknown contact insurance company.)

For a visit to a local physician or other health care provider, the following information is necessary or send a copy of insurance card and a list local physicians with this form:

Insurance Company Name: _____ Customer Service Phone Number: _____

Insurance Company Mailing Address: _____

Policy Holder Name: _____ Policy Number: _____

Group Number: _____ Member ID Number: _____ Co-pay Amount: _____

***Student Health insurance will be offered through a provider. Students must sign up within 30 days of registration for more information please call (501)-279-4380.**

IF YOUR CHILD IS THE AGE OF SEVENTEEN OR UNDER WHEN HE/SHE COMES TO THE UNIVERSITY, PLEASE COMPLETE THIS FORM.



GRANT OF MEDICAL AUTHORITY AND RELEASE

I/we, am/are the parent(s) and/or legal guardian of _____ and by virtue of such relationship, do hereby give to Harding University, Inc. and to any and all members of its faculty, staff, or administration, the unqualified right and authority to take whatever reasonable action or procedures, including the execution of any documents or instruments, which may be required or necessary by emergency circumstances, to obtain medical, hospital or surgical care or treatment by a legally qualified physician or surgeon if such care or treatment is deemed necessary by the physician or surgeon for and on the behalf of _____.

This authority to act on my behalf shall not be affected by temporary or permanent disability, incompetency or incapacity. I/we understand that Harding University will attempt to contact me/us before authorizing such medical treatment.

I/we do hereby release and discharge Harding University, Inc. and all its agents/employees from any and all claims, demands and liabilities to me/us or to my/our child, on account of any and all injuries or damages, whether direct or indirect occasioned by and through the exercise of authority granted in the foregoing paragraph.

I/we do further accept the financial responsibility for all medical attention which may be needed so long as this medical attention is prescribed by a legally licensed and qualified physician or surgeon. I/ we will be responsible for filing any claims, if any, with my/our insurance company.

The provisions of this agreement are servable. If any portion of it is invalid, it shall not affect the validity of the remainder.

In witness whereof, I/we, hereunto set our hands on this _____ day of _____, 20____.

Signature of Parent of Minor Student

STATE OF _____

Signature of Parent of Minor Student

COUNTY OF _____

I, a Notary Public within and for the State and County aforesaid, do hereby certify that the forgoing instrument of writing as this day executed before me in said State and County by the party (ies) hereto and was executed and acknowledged by him/her/them to be his/her/their free act(s) and voluntary deed(s).

WITNESS my signature on this _____ day of _____, 20____.

My Commission Expires: _____

Notary Public