REQUEST FOR NON-DISCLOSURE

I, _____, am requesting that my visit and all
Please Print Name

associated charges with the Campus Health Service on _____ for
Date

_____ not be billed or disclosed to my insurance company.
Reason for Visit

- ☐ **I understand I will be charged fee-for-service rates based on my eligibility.**
- ☐ **I understand that once I have received the above services, I will not be able to change and have my insurance billed retroactively.**

_____ _____
Signature Date

_____
Student I.D.