The University of Oklahoma
Goddard Health Center
620 Elm Avenue
Norman, OK 73019-3146

This completed form is required at each visit if you are not covered by insurance or covered by Soonercare, Medicaid or the Oklahoma Health Care Authority.

If you are not covered by Insurance, please circle:

NO COVERAGE Initials_____

Do you have Soonercare, Medicaid or Oklahoma Health Care Authority Coverage?

YES_____ NO_____ Initials_____

Goddard Health Center is not a Soonercare/Medicaid/Oklahoma Health Care Authority provider and cannot be your Soonercare/Medicaid/Oklahoma Health Care Authority home. Soonercare/Medicaid/Oklahoma Health Care Authority will not cover the cost for your visit, any services received or any prescriptions written by our Goddard provider.

You will be responsible for all charges for your visit and services, including prescriptions from Goddard providers and will receive a Bursar statement for all charges not paid at the time of service.

If you have questions about what you will be required to pay, you may ask Patient Services or the Pharmacy for cost estimates prior to receiving services or filling a prescription.

I understand this information and would like to receive services at Goddard Health Center and am willing to pay for all charges incurred.

Signature _____

Date _____

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If you are covered by insurance, please complete the following:

Has any of the information changed since your last visit? Yes ☐ or No ☐

Primary Insured/Policy Holder Information *for your medical insurance*
(this is the person who "owns" the insurance if not you):

Last Name _____

First Name _____

Middle Name or Initial _____

Date of Birth _____

Mailing Address _____

City _____ State _____ Zip Code _____

Insurance Company _____

Insurance ID # _____

Insurance Group # _____

Patient's Relationship to Primary Insured _____

Your medical insurance cards (or complete information) are required to file your insurance in both the clinic and the pharmacy. Please be aware you will receive a Bursar statement for the remainder of any charges after insurance has processed your claim. If you have questions about what your insurance will pay or whether your insurance is in-network, please contact your insurance carrier. Your OU ID will be required at the time of service in the clinic. Your OU ID and your Driver's License (for some prescriptions) will be required at the time of service in the pharmacy.

I understand I am responsible for all charges not paid by my insurance and want to receive services at Goddard Health Center on the OU Norman Campus.

Patient Printed Name _____

Signature _____

OU ID _____ Date _____