Medicat #_____

University of Nevada Las Vegas
Faculty And Staff Treatment (FAST) Center Financial Agreement for Services

I understand that only Academic and Administrative Faculty, Classified and Executive Staff, Letter of Appointment employees, casual employees, and Postdoctoral scholars employed by the University of Nevada, Las Vegas, and the legal dependents of these employees, are eligible to receive medical and pharmaceutical services at the Student Wellness Faculty And Staff Treatment Center. I further understand that I (and/or my dependent) will be required to pay a $25 office visit fee for each visit, and that this fee does not apply to the deductible that is required by any health insurance plan provided by UNLV or any other health insurance plan. I further understand that I am responsible for any additional charges related to diagnostic laboratory tests, medical procedures, medical supplies, copies of medical records, or medications (prescribed or over-the-counter) that I receive in the Student Wellness FAST Center or Pharmacy.

I understand and acknowledge the following:

- Payment is due at the time services are provided.
- I am fully responsible for all charges incurred by my dependents receiving services at the Center or in the Pharmacy.
- A fee will be assessed for returned checks. The prevailing bank rate is assessed for any check returned unpaid by the bank. Any returned check shall be made good within ten (10) days after notification.
- If my account remains delinquent, the Student Wellness Center may send the account to a collection agency, and if so, I will be liable for all collection and litigation costs (34%), in addition to the balance on my account.
- I am responsible for providing accurate address information to the Student Wellness Center. I also acknowledge that failure to provide an accurate mailing address could result in my account becoming delinquent and being sent to a collection agency.

I have read and agree with the above conditions of the FAST Center Financial Agreement for Services.

Patient Signature:_____ Today's Date:_____

Print Patient Name: _____ Date of Birth:_____

FOR DEPENDENTS OF FACULTY OR STAFF

Parent or Representative Signature_____ Date:_____

Description of Legal Relationship:_____

Print Name: _____ Phone Number:_____