UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER

University Health Center
Building 140, Campus Drive
College Park, Maryland 20742
301.314.8180 TEL 301.314.7845 FAX

PATIENT CONSENT, ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY AGREEMENT

Patient/Client Name _____ Patient/Client ID # _____ (if applicable)

Consent for Treatment & Use of Records

I, the undersigned, voluntarily consent to treatment by the practitioners and clinical staff of the University Health Center. I also voluntarily consent to the use and disclosure of my protected health information (PHI) for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) without a written authorization. I understand that the University Health Center is an integrated unit including medical, mental health and health promotion/wellness and that my record may be shared between those internal departments for treatment purposes. In addition, the UHC actively collaborates with Athletic Training Services/Sports Medicine and the Counseling Center on the care of patients and my medical information may be shared with those units for the purpose of care coordination and delivery.

I understand that in cases of disclosure of threats to harm myself or others, or instances of past or present child neglect or abuse, disclosure and/or mandated reporting may follow in accordance with State law and/or University policies and practices. When required by the federal *Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act* (the "Clery Act"), UHC staff must anonymously report general information about crimes including the type, date and location of the incident. The victim's name and other personally identifying information will not be reported. In the event that a crime poses a serious or continuing threat, a timely warning of the crime will be issued to the campus community. I acknowledge that I have been offered the Notice of Privacy Practices (NOPP), which contains additional information about the use of my PHI. The NOPP is also available on the Health Center website.

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me.

In the event that this visit is based on a Worker's Compensation claim and my Worker's Compensation claim is not accepted, I agree to have the fees associated with services sent to my private health insurance company.

I acknowledge that not all services provided by the University Health Center are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of the Health Center as an out-of-network provider, and/or my failure to provide my insurance card. I acknowledge that physical therapy, acupuncture, and massage services are not billed to insurance carriers and I agree to be financially responsible for those services.

Authorization (PLEASE COMPLETE):

I authorize payment directly to the University Health Center for services for which the University Health Center accepts payment. I accept responsibility for all charges if I do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan. I elect to proceed with service with the understanding that I may be personally responsible to pay for the service being rendered to me.

In general, it is the policy of the University Health Center that photography, video and/or audio recording are not permitted in the Center.

_____ _____
Patient Signature Date

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my student until they turn 18. The Health Center will seek to notify parents in the event of an emergency.

_____ _____
Parent or Legal Guardian Signature for a minor Date

_____ _____
Witness Signature Date

GC Review 3/2019

Addendum B Mental Health Services Policy & Acknowledgement Form

Patient/Client Name _____ Patient/Client ID # _____

Confidentiality Policy: All Health Center records are confidential to the extent permitted by Federal and state law. Mental health information is also confidential but, in the interest of providing the best integrated treatment, information may be shared within the Health Center on a need to know basis**.**

I understand and acknowledge that there are exceptions to the confidentiality policy, as required by law, including:

1. When I have signed a Release of Information Consent Form for specified individuals or agencies; 2. When there is a court order, signed by a duly appointed or elected judge, for release of my records;
3. When I am perceived by University Health Center officials to be a danger to myself or others.

I also understand and acknowledge that in the following two instances a report will be made to the appropriate state agency, as required by law:

1. When I am suspected of abusing children or other vulnerable individuals; and
2. When I report that I was physically or sexually abused before the age of 18.

This policy is in effect now and at all times after I leave the University.

Application of the Family & Educational Privacy Act (FERPA)

If you are a student, your health records are covered by FERPA rather than the Health Insurance Portability & Accountability Act (HIPAA). FERPA and HIPAA have different exceptions that allow for disclosure of information without a patient's consent.

Procedures: Please ask your doctor or therapist any questions you may have about the above. Your cooperation with the following will help the Mental Health Service staff give you the best possible care and treatment:

- **Contact our office 24 hours in advance if you are unable to keep an appointment. If you miss your appointment or fail to cancel or reschedule 24 hours in advance, your account will be charged.**
- If you are in crisis or if your situation worsens between sessions, please contact the Mental Health Service. ➢ Discuss any questions you may have regarding any aspect of your treatment with your clinician. ➢ Be on time for your appointment.

All registered students will be charged a $15 fee per session for Mental Health appointments with a therapist, and $25 for visits with a prescriber. If this poses a hardship for you, please discuss this with your clinician. There is no fee for group therapy.

I hereby give my informed consent to receive mental health treatment. I understand that this will encompass the intake and diagnostic assessment process, as well as any therapy which may be recommended and undertaken.

I have reviewed and understand the issues related to confidentiality as stated above and I have been offered a copy of this statement of confidentiality for my own records.

_____ _____

Client Signature Date

_____ _____

Counselor/Witness Signature Date

Revision 7-2018