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 C CARE to Stop Violence Confidentiality Policies and Procedures for Service Provision Acknowledgement Form**

Patient/Client Name _____ Patient/Client ID # _____

All contacts with the CARE to Stop Violence Office are confidential.

I understand and acknowledge the following:

*EXCEPTIONS* apply to CARE's ability to provide confidentiality include:

1. When I sign a waiver to release my confidential information held by CARE to a specific individual or entity, the information disclosed is no longer confidential.
2. When there is a court order, signed by a duly appointed or elected judge, for release of my records.
3. When I waive all rights to confidentiality by knowingly engaging in illegal activities in relation to CARE resources, personnel or offices.
4. For data reporting purposes regarding client demographics of basic anonymous statistical information.
5. If I am perceived by CARE staff to be a danger to myself or others.
6. When I have requested or received any electronic correspondence (i.e. email) from the CARE office; is not encrypted and cannot be guaranteed as confidential despite the email being sent to appropriate party.

I further understand and acknowledge that for the types of abuse listed below that I may communicate to CARE staff, that such information requires CARE staff to make are report to the appropriate state agency, as required by law:

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

**Application of the Family & Educational Privacy Act (FERPA)**

If you are a student, your student records, including 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.

I have been informed about how to access the UMD Sexual Misconduct Policy & Procedures online and have been informed of my right to file a report with the Office of Sexual Misconduct & Relationship Violence and the University of Maryland Police or Prince George County Police, depending on the circumstances of my situation. I have read, or have had read to me, all the information stated above. I hereby give my informed consent to receive CARE services.

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