DIVISION OF STUDENT AFFAIRS
UNIVERSITY HEALTH CENTER

University Health Center
3983 Campus Drive
College Park, MD 20742
TEL: 301-314-8180
FAX: 301-405-9755

Patient/Client Name: _____ Patient/Client UID #: _____

PATIENT CONSENT, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY AGREEMENT

Consent for Treatment & Use of Records

I, the undersigned, voluntarily consent to medical treatment by the University Health Center and/or its affiliated entities (collectively, "UHC"), including without limitation any physician, other licensed provider, or clinical staff assigned to my care. This treatment may include exams, medications and prescriptions, laboratory tests, radiology, electrocardiography, or any other services deemed necessary for my care and safety. I understand that some of the providers furnishing services to me, including but not limited to pathologists, radiologists, cardiologists, and dermatologists are agents of UHC.

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 written authorization.

I understand that the UHC is an integrated unit that includes medical, psychiatry, substance use intervention and treatment, sexual and reproductive health, health promotion and wellness, Campus Advocates Respond and Educate (CARE) to Stop Violence, and Sports Medicine, and that my record may be shared among those internal departments for treatment purposes. In addition, the UHC actively collaborates with the Counseling Center in patient care, and my medical information may be shared with those units for 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. If a crime poses a serious or continuing threat, a timely warning 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 UHC 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.

If this visit is related to a Workers' Compensation claim or an automobile or accident insurance claim and the claim is not accepted or denied, I agree that the fees for services may be billed to my private health insurance company.

I acknowledge that not all services provided by the UHC 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 UHC as an out-of-network provider, and/or my failure to provide my insurance card. I acknowledge that some UHC services are not billed to insurance carriers, and I agree to be financially responsible for those services.

OGC Reviewed 4/2026

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Authorization (PLEASE COMPLETE)

I authorize payment directly to UHC for services it accepts payment for. 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 for paying for the service being rendered to me.

I understand and agree that the UHC, its affiliates, agents, contractors, or designees (including but not limited to debt collectors) may contact me regarding services, payment for services, scheduling appointments and healthcare operations activities through various methods including without limitation the use of manual representative outbound calls and voice messages, and/or text messages, at any telephone number I provide to the UHC. If I provide the UHC with an email address, I agree to receive email messages from the UHC. These emails may contain my health information and may not be encrypted. Unencrypted emails may create potential privacy and security risks. I understand that I am not required to accept messages in these formats as a condition of receiving services at the UHC. I also understand that I have the option to "opt out" of receiving such communications, which I may exercise at any time by notifying UHC in writing. I understand that opt-out processes may take a reasonable amount of time to go into effect. Unless I have opted out, communications may continue after this form expires (two years from the date on the form).

In general, it is the policy of the UHC that photography, video, and/or audio recording by patients/clients, visitors, and other third parties is not permitted on the premises. UHC staff may take photographs and recordings of me during my care for purposes of identification, diagnosis, and treatment. As permitted by law, I further understand that photographs or recordings may be created and used for educational, quality improvement, research, and teaching purposes.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

Signature of Patient	Date
I give permission for any diagnostic and therapeutic procedures deemed necessary for the minor patient until the minor turns 18. The UHC will seek to notify parents and legal guardians in the event of an emergency.	
Printed Name of Personal Representative (for minors under the age of 18)	Relationship to Patient
Signature of Personal Representative	Date
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

OGC Reviewed 4/2026