UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER

University Health Center
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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 A Substance Use Intervention & Treatment Program Confidentiality Form

Patient/Client Name _____ Patient/Client ID # _____

Confidentiality Policy

As a client of the University of Maryland's Substance Use Intervention and Treatment Program, you are automatically accorded certain rights, including confidentiality rights.

The confidentiality of alcohol and drug use patient records maintained by this program is protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user *unless:*

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Exceptions

Federal laws and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Violation of the Federal law and regulations by a treatment program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

(See 42 U.S.C. §§ 290dd-2 for Federal laws and 42 CFR part 2 for Federal regulations.)

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. The Federal regulations that cover the confidentiality of alcohol and drug use patient records supersede both HIPAA and FERPA.

Procedures

Please ask your counselor any questions you may have about the information provided above. Your cooperation with the following procedures will help the Substance Use Program staff give you the best possible care and treatment.

1. **Contact our office 24hrs in advance if you are unable to keep an appointment. If you miss your appointment or fail to cancel or reschedule 24hrs in advance, your account will be charged a $25.00 fee.**
2. If you are in crisis or if your situation worsens between appointments, please contact the Substance Use Program.
3. Discuss any questions you may have regarding any aspect of your treatment with your counselor.
4. Be on time for your appointment.

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