UNIVERSITY OF GEORGIA
University Health Center
Student Affairs

UNIVERSITY HEALTH CENTER
The University of Georgia
Athens, GA 30602-1755
Phone: 706-542-1162
Fax number: 706-542-4959/583-0777

NAME: _____

UGA ID#: _____

Date of Birth: _____

UNIVERSITY HEALTH CENTER PATIENT AGREEMENT

Permission for Diagnostic and Treatment Procedures

I authorize University Health Center (UHC), their employees and consultants to perform diagnostic and treatment procedures which, in their judgement, may become necessary while I am a patient at the University of Georgia. This may include the use of clinical photography for purposes of diagnosis and treatment. I agree that I will be involved and engaged in my care and treatment. I understand that UHC may utilize the services of Physician Assistants and Nurse Practitioners, and I have the right to consult with a physician prior to receiving a prescription drug or device order. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that telehealth services are not routinely available at UHC. These services are available on a case-by-case basis at the discretion of the provider. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of University of Georgia.

Confidentiality and Notice of Privacy Practices Acknowledgment

Medical and mental health information contained in all health records is strictly confidential and may only be released with written permission from the patient, by a court order, or as otherwise permitted by law. I understand that if a UHC provider refers me to an outside provider or needs to obtain prior authorization for a medication, treatment or procedure, my records pertaining to that referral or authorization will be released. Confidentiality and privacy are protected in all UHC business relationships to prevent the exchange of any patient-specific information without permission. I understand that I have certain rights to privacy in regard to my confidential health information. UHC's Notice of Health Information Privacy Practices is available online at healthcenter.uga.edu/info/confidentialty. University Health Center reserves the right to change the terms of its Notice of Health Information Privacy Practices. If such changes are made, I understand that the Notice of Health Information Privacy Practices will be posted on the UHC website, and I can request a copy at any time**. Patients may not photograph, video or audio record or other imaging within the University Health Center without obtaining prior written consent/approval from all staff involved in the treatment/care.**

Access to Your Health Information

Your health information is accessible on the patient portal while enrolled. You can print from the portal or request a full copy up to 10 years after your last visit, at which point your records may be destroyed for security. UHC staff who are involved in your care can and will view your records only as needed. Protect your privacy by keeping portal credentials secure and confidential.

Financial Responsibility and Authorization to Process Insurance Claims

Patients and clients are responsible for all charges for services incurred by themselves or family members for services at UHC. Examples of charges include office visits, lab tests, radiology services, prescriptions, dental procedures, vision procedures, physical therapy, vaccinations, and others. Eligible UHC patients and clients who have scheduled appointments are subject to a charge for late arrival or missed appointments. Patients and clients are encouraged to be covered by health insurance, either by a family policy or an individual policy. Insurance information is to be supplied to UHC prior to the first visit and updated annually, or whenever the insurance changes. UHC will file insurance claims on behalf of patients and clients; however, **that does not guarantee full or partial payment by insurance companies, and patients and clients remain responsible for any unpaid balances.** The UHC Pharmacy will file your insurance for prescriptions written by UHC or non-UHC providers. Upon notification from an insurance company, patient-and-client responsible charges are placed on the patient's and client's UHC account, and an administrative hold is placed on the student's UGA records. This hold may prevent registration for future semester UGA classes.

I, the undersigned, have read and understand this information and authorize the release of medical and other necessary information to my insurance company to process claims for services rendered. I hereby authorize the insurance company to distribute payment for my coverage directly to UHC. I understand that I am responsible for all charges regardless of my insurance benefits and whether incurred by myself or a family member. I authorize the use of this signature on insurance submissions. I may elect to pay any bill myself in lieu of submitting a claim for insurance reimbursement. I further agree that if UHC refers all or part of the unpaid portion of any bill to an attorney or agency for collection, I am liable for and shall pay UHC's attorney fees and/or collection agency fees resulting from the referral. I agree to pay all charges and other costs, including attorney fees, that are allowed by federal and state laws and regulations and that are necessary for the collection of these amounts.

I verify by my signature below that I give permission for diagnostic and treatment procedures; I have been informed of my privacy rights; I am responsible for charges on my account and authorize release of my health information to process any insurance claims.

_____
Signature of patient (or Parent if patient is under 18)

_____
Date

_____ Verbal consent given by parent via phone. Obtained by: _____ Date: _____

2.1.1.A1
Reviewed 11/07, 4/11, 10/11, 7/17, 6/18, 1/23, 5/24
Revised 7/08, 12/08, 5/10, 7/12, 5/14, 5/15, 12/15, 9/16, 1/17, 6/21, 8/22, 3/23, 6/23, 10/24, 12/24, 2/25