UNLV

UNIVERSITY OF NEVADA LAS VEGAS

Student Health Center

CONSENT FOR MEDICAL TREATMENT AND USES AND DISCLOSURES OF PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO)

Please read, complete and sign the back of this consent form.

I give my permission to the University of Nevada, Las Vegas Student Health Center to educate, interview, examine, perform laboratory procedures and to treat my condition, as they deem necessary. I understand that in case of a life-threatening emergency, this consent may be implied for the time of the emergency.

I understand that the Student Health Center is a teaching institution. Therefore medical residents, medical students, nurse practitioner students and nursing students may participate in my care under the supervision of a physician or nurse practitioner. I understand that other outside medical professionals may also be consulted as deemed necessary for my care.

For coordination of my care and services, I understand that I may be provided with referrals to off campus specialists and the Student Health Center may assist other treating physician in provision of my care.

Informed Consent: If my condition requires an outpatient surgical procedure, the practitioner responsible for my care will explain to me the procedure to be performed, the general nature and extent of risks involved in such procedure and the alternative method, if any.

Consent for Minor Students: If you are a minor, we must have a signature of the parent or legal guardian (appointed by a court of law) on this form before any general treatment may begin, and such consent must be effective until you reach legal age in the state of Nevada (18 years old).

❋ **Exemptions to this consent are:** A life-threatening emergency, Treatment for emancipated minors with court supporting documents and per **NRS 442.255** and **NRS 129.060** for family planning and contraceptive methods, screening for sexually transmitted infections, counseling and treatment of alcohol and substance abuse.

APPOINTMENT POLICY:

- I agree to arrive at least fifteen (15) minutes early for my appointment.
- I understand that my appointment may be cancelled if I'm late.
- I will check-in at the intake window upon my arrival.
- If I miss two (2) consecutive appointments, (except cancellations or reschedules), I may be instructed to meet with the SHC Assistant Director or designee before scheduling another appointment.
- I agree to call 24 hours in advance to cancel my appointment if I'm unable to show.
- If I miss two (2) consecutive appointments with the GYN or Dermatology specialist, (except cancellations or reschedules), I will be referred off-campus for any further specialist services.

◄ Please turn page for additional uses and disclosures of health information ►

I understand and agree that the Student Health Center will not use or disclose protected health information for any purpose other than treatment, payment and healthcare operations or for certain other limited purpose, unless such person or entity is authorized to receive such information under law or I have provided a written authorization. (***See full explanation of disclosures and rights in the Notice of Privacy* Practices posted in the lobby or visit our website http://www.unlv.edu/studentlife/shc/forms.html**) If I am being treated while I am a student, I consent and agree that my health information may be used and disclosed in accordance with the Notice of Privacy (and any posted revision of that Notice) and the federal Health Insurance Portability and Accountability Act.

In the process of receiving health care at the Student Health Center, a provider may initiate a follow up call and a letter may be sent to continue care. Also, patients may receive phone calls to remind them of a scheduled appointment.

I understand that **if** I agree to participate in a research study, I will be provided with a specific authorization to participate. (***See Notice of Privacy* Practices**). I have the option to choose not to participate or to withdraw from the study at any time.

I understand that I have the right to revoke this consent in writing, unless the Student Health Center has already used or disclosed my information in reliance on the consent.

I understand that I have the right to request restrictions on certain uses and disclosures of my health information to carry out treatment, payment, or healthcare operations and that the Student Health Center is not required to agree to the restrictions requested.

Please note: I understand that if I request a restriction that may impede the ability to provide proper care, or which restricts the release of information required by law to be released, that we are unlikely to agree to the restrictions and may cancel further services. Further, if I request a restriction that does not allow us to release necessary information to insurance providers; it may affect my ability to obtain reimbursement for medical expenses.

I acknowledge receipt of a copy of the current Notice of Privacy Practices, which contains a more complete description of uses and disclosure of patient health information.

I understand that the Student Health Center reserves the right to change the Notice of Privacy Practices and a revised copy will be posted and available when requested.

Patient Signature:______________________________ **Today's Date**: ________________

Print Patient Name:______________________________ **Date of Birth**: ________________

For students 17 years old and under:

Patient Parent or Representative Signature:______________________________ Date:____________

Description of Legal Guardianship:______________________________ Phone No.____________

Print Name:______________________________ Phone No.____________