

## CONSENT FOR TREATMENT

The Student Health Service collects health information from you and stores it in written and electronic formats. This health information is the property of the Student Health Service, but is accessible to you. The Student Health Service protects the privacy of your health information. However, the law permits the Student Health Service to use or disclose your health information for the following purposes:

**Treatment:** Your health information can be used or disclosed by the Student Health Service in order to provide you with medical treatment.

**Payment:** Your health information can be used or disclosed by the Student Health Service to enable us to receive payment.

**Operations:** Your health information can be used or disclosed for Student Health Service operational purposes.

**Personal Use:** Your health information can be disclosed to you.

Once you sign this consent form, it will be in effect indefinitely until you revoke it. You may revoke your consent at any time by writing to the Student Health Services Medical Records Manager, except to the extent that we have already relied on it. For example, if we provide you with treatment before you revoke your consent, we may still share your health information with your insurance company to obtain payment for that treatment.

I hereby authorize the Stony Brook University Student Health Service staff:

- To access information from my health history and records,
- To administer and perform any medical examinations, treatments, or diagnostic procedures deemed necessary,
- To administer vaccinations and immunizations related to my health care during my enrollment as a student at Stony Brook University.
- To provide me a medical note upon my request, as determined to be appropriate by a practitioner. This note will include my name, the date of visit, or other information requested by myself.

In addition, I understand:

- I may be asked to give specific consent for certain medical procedures.
- I have the right to refuse diagnostic or treatment services, or to revoke this consent.
- My provider may consult with other professionals within the Student Health Service, the University Counseling Center, University Hospital, and the Athletic Training Office, about issues directly related to my treatment.
- In situations in which your condition may pose a health or safety risk to yourself, other students, or staff, the Student Health Service may release the relevant medical data to designated University officials.
- All information that is part of my medical record at the Student Health Service, will be handled with strict confidentiality, in accordance with law.

I understand that there are important legal exceptions to this confidentiality including, for example:

1. Reportable conditions, such as meningitis, tuberculosis, and specific sexually transmitted infections, which constitute public health risks.
2. Threat of immediate danger to self or others, such as suicidal tendencies, malnutrition, self-abuse, overt aggression.
3. Any incidence of suspected elder or child abuse, neglect, or maltreatment.
4. Court-ordered disclosure of clinical records.

I also understand that in the event of a medical emergency, information necessary to provide appropriate treatment may be disclosed.

*By signing this consent form, I am acknowledging that I have read and understand the above material regarding Stony Brook University Student Health Service procedures. I hereby authorize the Student Health Service and its medical staff to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment, facilitating the payment for such treatment and for normal business operations. I also understand that I am responsible for fees that may be charged for missing any appointment that I have scheduled and fail to cancel in a timely fashion.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
ID #

\_\_\_\_\_  
Signature Parent /Legal Guardian (If under age 18)

\_\_\_\_\_  
Date

OVER

**Stony Brook University Student Health Billing Policy Acknowledgement Form**

**All students are required to pay the Stony Brook University Infirmary Fee.** The fee covers comprehensive health services for both medical and mental health problems, for students and visiting scholars. This fee is not a substitute for health insurance. The Student Health Service building is the only location on campus where the mandatory health fee can be applied toward medical service. Medical Services that are beyond the scope of the Student Health Service can be obtained either at University Hospital Medical Center or through other medical providers in the community. **The Infirmary Fee will not cover the cost of any medical and laboratory services outside the Student Health Service building.** You will receive a separate bill for services performed by outside labs and practitioners.

The following sets forth the general billing policy of the Student Health Service. Please review this information and sign where indicated.

- ❖ I understand that it is my responsibility to provide the Student Health Service with current, accurate billing information at the time of check in and to notify them of any changes in this information. I also understand it is my responsibility to notify the Student Health Service in any instance in which I do not want to use my insurance coverage.
- ❖ I understand that it is my responsibility to know my co-pays and in which situations they apply. I understand that this is a contractual agreement that I have with my health plan.
- ❖ I understand that I will be billed by the University for any amounts due from me including, but not limited to, co-payments, coinsurance, and deductibles, and that I have a financial responsibility to pay these amounts. I further understand that my balance may be sent to a collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- ❖ I understand that there are some procedures, physical examinations, immunizations, supplies, over the counter medications and prescription pharmaceuticals that are not covered by the Student Health Fee. A copy of these fees can be supplied to me at my request. I am responsible for understanding, in particular, my pharmaceutical insurance coverage (if any) as it relates to any of these fees.
- ❖ I understand that certain routine screening laboratory tests which are sent to outside labs, in most cases, are not covered by insurance. I understand that it is my responsibility, not the treating practitioner, to know which tests are part of my physical exam and may or may not be covered. For example, screening for sexually transmitted infections without symptoms are not covered by many insurance plans.
- ❖ I understand that the Student Health Service acts as a drawing station for outside laboratories. Those laboratories will bill me for the costs of the tests sent to them.

My signature below confirms that I have read these billing policies and understand my financial obligation as it pertains to the Student Health Service. I am aware of and accept my responsibilities as a patient. I further understand that fees, particularly those from outside laboratories, vendors, and offices, may change at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have been provided a copy of this Consent and Acknowledgement Form and have been advised of how personal health information may be used and disclosed by health care facilities of the State University of New York, and how I may obtain access to and control the distribution of such information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

\_\_\_\_\_  
Signature of Patient or Personal Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Print Name of Patient or Personal Representative