Health Services
9801 Frankford Ave., Philadelphia, PA 19114
Phone: (267)341-3262 | Fax: (267)341-3691

General Consent, Acknowledgement and Authorization

Patient's Name (PRINT):_____ Date of Birth:_____ Student ID Number:_____

Consent to Treatment

I, _____ (patient's name) consent to in person and virtual visits conducted by a Holy Family University Health Services Registered Nurse or Nurse Practitioner while enrolled as a student at Holy Family University ("University"). I consent to evaluation and treatment of the condition for which the undersigned has come to Holy Family University Health Services. I authorize a licensed Nurse Practitioner or Registered Nurse employed by the University to provide such evaluation and treatment. I consent to any physical examinations, injections, collection of laboratory specimens, venipuncture, and other testing deemed necessary during my visit with the Holy Family University Health Services' providers or employees. I understand and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any treatment, evaluation, diagnosis, or test performed at Holy Family University Health Services. I authorize Holy Family University Health Services to examine, use, dispose, and store my specimens, bodily fluids, and tissues. I understand that the services at Holy Family University Health Services will be provided by a Pennsylvania licensed Nurse Practitioner or Registered Nurse. I agree to ask any questions that I may have before or during treatment. I agree that this consent will be applicable to all visits, emergency care, or episodes of treatment and evaluations by the Holy Family University Health Services' providers or employees.

Confidentiality

Virtual appointments are conducted using a virtual platform. Doxy.me, LLC is a Covered Entity and Business Associate that is required to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), including applicable privacy, security, breach notification and enforcement rules, as well as the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, as amended, and other applicable federal and state laws.

Holy Family University Health Services is required to maintain the privacy and security of your protected health information. All services provided by Holy Family University Health Services are confidential and will not be released to a third party without your authorization unless disclosed for purposes of treatment, payment or health care operations. Ethical and legal guidelines permit disclosure when a student is in critical condition or there is a threat to self or others. The University will not use or share your information other than as described herein, unless you authorize us to do so. If you provide such authorization, you may change your mind at any time prior to disclosure, but you must inform the University in writing if you change your mind.

I acknowledge that I have had an opportunity to read and review the information contained in the Holy Family University Health Services' Notice of Privacy Practice, which is found on the University's website.

Acknowledgment of Financial Responsibility

Services provided by Holy Family University Health Services are free to students, with some exceptions. Any laboratory tests and specimens (titers, urine cultures, throat cultures, etc.) sent to an outside lab will be charged to the student's health insurance. Any prescriptions will be charged to the student's health insurance. Any referrals, additional testing, and follow up visits through another provider or organization will be charged to the student's health insurance. If the student does not have health insurance, all acquired cost will be billed directly to the student and will be the financial responsibility of the student. It is the student or policy holder's responsibility to verify coverage for all lab test, prescriptions, and/or referrals prior to the visit. Holy Family University Health Services can change the terms of the cost, payments, and reimbursement for their services at any time.

I understand that I am responsible for paying the cost of any services at the time services are provided, and responsible for making payments in full for all services. Holy Family University Health Services is not responsible for obtaining reimbursement on my behalf or assisting in obtaining reimbursement from any sources. I understand that I am responsible for any charges that I incur by choosing to use the services of Holy Family University Health Services.

By signing below, I confirm my understanding of the above information and my consent to the above disclosures. You must be over the legal age of 18 years old, to sign this form of consent.

Signature:_____ Date:_____

If signed by anyone other than the patient, check the box that describes the relationship to the patient:

□ Parent □ Guardian □ Healthcare Agent □ Other (describe) _____