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

General Consent, Acknowledgement and Authorization Form

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

Student ID Number: _____ Phone Number: _____

Consent to Treatment

I, _____ (patient's name) consent to evaluation and/or treatment of the condition for which I, or my dependent, has come to Holy Family University Health Services, and authorize the licensed Nurse Practitioner employed by Holy Family University to provide such evaluation and/or treatment. I consent to all physical examinations, injections, collection of laboratory specimens, venipuncture, and all other testing deemed necessary during a visit with the Holy Family University Health Services' providers. 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 preformed at Holy Family University Health Services. I authorize Holy Family University Health Services to examine, use, dispose, and store all specimens, bodily fluids, and tissues removed from the patient's body. I understand that the services at Holy Family University Health Services will be provided by a licensed Nurse Practitioner. I agree to ask any and all questions before injections given, laboratory specimens are collected, and/or appropriate testing is performed. I acknowledge and 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.

Confidentiality

We are required by law to maintain the privacy and security of your protected health information. All services provided by Holy Family University Health Services are confidential, and are not released to a third party without written permission. Ethical and legal guidelines permit disclosure when a student is in critical condition or there is a threat to self or others. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know 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.

Acknowledgment of Financial Responsibility

Services provided by Holy Family University Health Services are free to students, with some exceptions. Any and all laboratory tests and specimens (titers, urine cultures, throat cultures, etc.) sent to an outside lab (LabCorp) will be charged to the student's health insurance. LabCorp is the only laboratory that Holy Family University Health Services uses to process ordered laboratory tests. Any and all prescriptions will be charged to the student's health insurance. Any and all referrals, additional testing, and follow up visits through another providers or organization will be charged to the student's health insurance. If the student does not have health insurance, all acquired cost are billed directly to the student, and are the financial responsibility of the student. It is the student or policy holder's responsibility to verify coverage of any and all LabCorp 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 any and all services. Holy Family University Health Services is not responsible for obtaining reimbursement on my behalf, or assisting me in obtaining reimbursement from any sources. I understand that I am responsible for any charges that I incur by choosing to utilize 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