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

NAME: _____

UGA ID#: _____

Date of Birth: _____

UNIVERSITY HEALTH CENTER PATIENT AGREEMENT

Permission for Diagnostic and Treatment Procedures

I, _____, hereby authorize University Health Center (UHC), their employees and consultant to perform diagnostic and treatment procedures which, in their judgement, may become necessary while at the University of Georgia. I understand that I will be involved and engaged in my care and treatment. I understand that UHC utilizes the services of Physician Assistants, and I have a 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 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 not be released without express written permission from the patient or by a court order. Confidentiality and privacy are protected in all UHC business relationships to prevent the exchange of any patient-specific information without permission.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Family Educational Rights and Protection Act (FERPA), I have certain rights to privacy in regard to my protected health information (PHI). By signing below, I acknowledge that I have received, read, and understood the University Health Center's Notice of Privacy Practices. This notice is available online at www.uhs.uga.edu. University Health Center reserves the right to change the terms of its Privacy Notice. If such changes are made, I understand that the Privacy Notice will be posted on the UHC website, and I can request a copy at any time.

Financial Responsibility and Authorization to Process Insurance Claims

The UHC is a participating provider with UGA's Student Health Insurance Plan and most Aetna, Blue Cross Blue Shield (BCBS), Standard Tricare, United Healthcare, Cigna, Humana, and Coventry plans. Patients and clients are responsible for providing current and accurate insurance information and a copy of their current insurance card and for knowing what their insurance policy covers at the UHC. The UHC Pharmacy is in-network with many insurance plans for prescriptions written by UHC or non-UHC providers.

Patients and clients are responsible for all charges for services incurred by themselves or family members for services at University Health Center. Examples of charges include office visits, lab tests, x-rays, prescriptions, dental procedures, vision procedures, physical therapy, vaccinations, after-hour visits, and others. 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.** 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/client Date

_____ _____

Signature of parent (if patient/client is under 18) Date

Reviewed 11/07, 4/11, 10/11
Revised 7/08, 12/08, 5/10, 7/12, 5/14, 5/15, 12/15, 9/16