University of Miami Student Health Services - Consent for Medical Treatment-Minor

COMPLETE AND SUBMIT ONLY IF YOU ARE A MINOR UNDER THE AGE OF 18

Patient Name: _____

UM ID #:_____Date of Birth: _____

1. CONSENT FOR MEDICAL TREATMENT

I, the undersigned, hereby consent to any and all diagnostic procedures, tests, medical treatment, and hospital care required in the diagnosis of my illness and course of treatment by the physician or his/her designee, medical staff and other agents, and/or employees of the University of Miami Student Health Service, University of Miami and/or University of Miami Medical Group (UMMG) (collectively, the "University"), including supervised residents and medical students. I recognize that the University of Miami is a teaching and research facility and that my treatment and care will be observed and in some instances aided by residents or medical students in their course of training. Additionally, I consent to the use of my medical data and non-identifiable photographs for educational and research purposes. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any other services rendered.

2. RELEASE OF MEDICAL INFORMATION (Third Party Payers, Guarantors, Physicians)

By signing this form, I hereby authorize the University to use and release information and/or copies of my medical records as necessary for my treatment, for payment for that treatment and for the health care operations of the provider treating me; including to the Hospital, Physician or other Provider, Guarantor, of my accounts, or third party payers for which I have assigned benefits for my treatment and care, and, if requested, to my referring physician, or any other healthcare provider responsible for my care. This includes information pertaining to psychiatric and/or psychological care, alcohol and/or substance abuse, AIDS or HIV diagnosis, testing and/or treatment for this period of illness as well as medical and other information as necessary for the operations of the Hospital or Physician or as required to secure payment for charges incurred by me or on my behalf, including a diagnosis of my medical condition.

3. RELEASE OF LIABILITY FOR LOSS OF PERSONAL PROPERTY

I release the University and the facilities in which services are rendered from liability resulting from the loss by theft or negligence of any employee of the institution or of any third party. I agree that I am responsible for any item(s) I keep with me in my possession, including, but not limited to electronic equipment, money, eyeglasses, jewelry or any other personal items.

4. HEALTH AND COUNSELING CENTERS

I understand that my medical records are confidential except when release is authorized by me or required by law. I understand that if I threaten to harm myself, and/or others, the University may be obligated to seek my hospitalization and/or disclose information contained in my medical records. I also

authorize the staff at the University of Miami Student Health Service to discuss my case and treatment amongst themselves and to consult the staff at the University Of Miami Counseling Center to coordinate care and/or treatment when professionally appropriate and/or medically necessary.
If a patient is under 18 years of age and is not legally emancipated, s/he should be aware that the law in most cases allows parents to examine their child's treatment records, unless the physician believes that such a review would be harmful to the client and to his or her treatment.

5. PAYMENT FOR SERVICES

I understand that many services including many routine visits are provided at no charge to eligible students and that other services including specialty clinic visits, x-ray, non-routine lab charges and immunizations can be paid for at time of service by cash, checks, or credit card or under certain circumstances can be submitted for payment from my insurance provider.

I understand that if charges are submitted to my insurance provider, final payment of all charges, including any balances remaining after partial payment from my insurance provider remains my obligation. Payment from my insurance company may be subject to deductibles, co-payment, and co-insurance and may be processed by my health plan as "out-of-network" leading to a lower level of coverage. After attempts to collect from me, any amount not covered by my insurance plan may be placed on my student account.
I understand that it is my responsibility to know and understand my plan coverage, co-payments, deductibles, and co-insurance and total out of pocket expense and that if I have an HMO insurance plan, my insurance company may require a referral or pre-authorization to be seen at the University of Miami-Student Health Service. If this applies, and I elect to have to have my insurance company billed for services rendered, it is my responsibility to contact my insurance company to verify benefits and financial responsibility.
I understand and acknowledge by signing this document that I give the University of Miami-Student Health Service permission to file a claim to my health insurance carrier for the purpose of payment for services received. I further understand and agree that the Student Health Service may not be a contracted provider with my individual health insurance plan and that I may be responsible for any unpaid balance, or services not covered by my insurance plan

6. TELEHEALTH SERVICES

This document is your consent to receive telehealth services through the University of Miami Student Health Service. Telehealth service is the delivery of healthcare services when the healthcare provider (referred to as Provider in this document) and the student are not in the same physical location/site through the use of various technology. Information provided may be used for diagnosis, therapy, follow-up and/or education, and may include any combination of the following: (1) medical records; (2) medical images; (3) live two-way audio and video; (4) interactive audio; and (5) output data from medical devices and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of identification and imaging data and will include measures to safeguard the data and to safeguard its integrity against intentional or unintentional corruption.

Primary responsibility for your medical care should remain with your local primary care doctor, if you have one, as does your medical record.

To participate in telehealth services, you understand that you will need a computer or tablet device with a camera for videoconferencing, speakers or headphones, and a good internet connection or good telephone reception. You will need to be in a private location to ensure your privacy.

Since this may be different than the type of consultation with which you are familiar, it is important that you understand, acknowledge and agree to the following statements:

*** I understand that I have undertaken to engage in a telehealth encounter that will contain my personal identifying information as well as my health information.

*** This consent will remain in effect until I withdraw it. I have the right to withdraw my consent to the use of the telehealth services at any time, which I may exercise by providing written notice to the University of Miami Student Health Service. The withdrawal of my consent will prevent me from using the telehealth services but it will not affect my right to future care or treatment should I seek it. Any withdrawal of my consent will be effective upon receipt of the written notice described above, except that such withdrawal will not have any effect on any action taken by a Provider(s) in reliance on this telehealth consent before the University of Miami Student Health Service received my written notice of withdrawal.

***I understand that University of Miami Student Health Service can only provide telehealth services to a student who is in the state of Florida at the time of the telehealth encounter.

*** I understand that there are limitations in the provision of medical care and treatment via telehealth services and that I may not be able to receive a diagnosis and/or treatment through telehealth services for every condition possible.

*** A Provider may determine in his or her sole discretion that my condition is not suitable for diagnosis and/or treatment using the telehealth services, and that I may need to seek medical care and treatment with a specialist or other healthcare provider, outside of the telehealth services.

*** I understand that the consulting healthcare provider will be at a different location from me.

*** I understand that it is my responsibility to make conditions or symptoms known to the Provider as well as to make arrangements for follow-up care.

*** I voluntarily consent to healthcare services provided which may include review of diagnostic tests, medications, examinations, and consultation on pre- or post- medical or surgical treatments considered necessary for treatment.

*** I will be informed and given the opportunity to verbally consent before additional persons at either the my or the Provider site are to be present.
*** I understand that there are risks and consequences from receiving telehealth health services, including, but not limited to, the possibility, despite reasonable efforts on the part of the University of Miami, that the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be accessed by unauthorized persons.

*** I understand that using a form of communication technology other than University of Miami approved telehealth applications may compromise security protocols or cause information transmitted to be insufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the consulting healthcare provider. I understand that such communications may not be included as part of my record.

*** I understand that the University of Miami will operate under the guidelines of the Family

Educational Rights and Privacy Act (FERPA) and applicable state statutes and regulations, to ensure confidentiality regarding the release of student information. No information will be released or secured without my prior approval, except as provided by law.

*** Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Providers, representatives of University of Miami, and/or other providers involved with the provision of telehealth services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts I may owe, the Providers, University of Miami, and/or other providers involved with the provision of telehealth services may contact me at the telephone number(s) provided which could result in charges to me by my telephone or internet provider. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre- recorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of receiving telehealth services.

*** If my Provider is concerned about me, loses contact with me, or if I fail to show for a scheduled telehealth services session, I grant permission for University of Miami to contact me by phone or email to check on my wellbeing.

*** I have been given the opportunity to ask the University of Miami questions relative to my Telehealth encounter, security practices, technical specifications, and other related risks
I certify that I have read or had read and/or had this form explained to me; that I fully understand its contents including the risks and benefits of telehealth services; and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

Signature of Parent or Legal Guardian _____

Date: _____

Relation to Student: _____
Home Phone #_____Work # _____
Cell # _____

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