Western Carolina University | Health Services

General Consent: Minors
Consent for Treatment
Consent to file insurance
Acknowledgement of Receipt of Privacy Practices

Date of Consent: _____ **Patient Name**: _____

Patient ID (920#)_____ **Date of Birth:** _____

CONSENT FOR TREATMENT/CARE:

I hereby authorize any medical treatment for myself that may be advised or recommended by the health services care providers of WCU. I am aware that the practices of medicine are not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations, procedures, or analysis.

ASSIGNMENT of INSURANCE BENEFITS:

I understand that Health Services does not participate as an in-network provider with all insurance carriers/plans but will submit an insurance claim on my behalf to both in-network and out-of-network plans. A full list of participating plans is available upon request. I hereby authorize WCU Health Services to submit an insurance claim for payment to my health insurance plan, and furthermore, I authorize direct payment to WCU Health Services of all health benefits payable by my insurance plan if WCU Health Services is a designated participating provider in my plan. For out-of-network plans, I am not assigning benefit, and acknowledge that I will receive any insurance reimbursement directly to myself. I understand that I am financially responsible to the university for charges not paid by insurance, or payments made directly to me from insurance. I am fully responsible for charges incurred during my visit.

ACKNOWLEDGEMENT of RECEIPT OF PRIVACY PRACTICES:

I attest that this office has made available to me of its Notice of Privacy Practices for my review. The Notice explains how my health information is protected and how it will be handled in various circumstances. I understand that it is the responsibility of this office to provide me with a copy of its Notice on the first service encounter after April 14, 2003. If my first date of service with this office was due to an emergency, I understand that it is the office's responsibility to provide me with this Notice and obtain my signature as acknowledgement of receipt as soon as possible following the emergency. I have reviewed WCU's Notice of Privacy/Provider Practices and have been given the chance to express my concerns and ask questions about the privacy of my health information.

North Carolina General Statute 122C-54(g); NCGS 122c-55(a), (a2), (d), (e)

"North Carolina law generally requires that we obtain your written consent before we may disclose health information related to your mental health services. There are some exceptions to this general requirement, however. We may disclose health information to members of the Health and Counseling Centers workforce to our professional advisory including the university attorney, and to agencies or individuals that oversee our operations or that help us carry out our responsibilities in serving you. We will disclose only the information that is necessary to the provision of services or operations, and the information will be disclosed only to individuals who have a need to know. We also may disclose information to the following people: (1) a health care provider who is providing emergency medical services to you; and (2) to other mental health professionals when necessary to coordinate your care and treatment. If we determine that there is an imminent threat to your health or safety, or the health or safety of someone else, we may disclose information about you to prevent or lessen the threat. We also well release information about you if state or

federal law requires us to do so, when a court of law orders us to do so, or to report suspected neglect or abuse of a child or disabled adult."

AUTHORIZATION by PARENT OR LEGAL GUARDIAN FOR MINORS (UNDER AGE OF 18):

I understand that my signature on this document constitutes my consent and acknowledgement of receipt of the information as stated above as the parent or legal guardian of this patient.

Please initial one of the following options:

_____ I am providing authorization to WCU Health Services to perform necessary medical testing and treatment for my child which is deemed advisable or necessary by the medical provider. This authorization is valid for today's visit and future visits for the remainder of this academic calendar or until my child is 18 and will provide consent for themselves. I understand I have the right to revoke my consent at any time.

_____ I am providing authorization to WCU Health Services to perform necessary medical testing and treatment for my child which is deemed advisable or necessary by the medical provider. This authorization is for today's visit only. I request for a separate consent to be obtained for any future visits

_____	_____	_____
Signature of Parent or Legal Guardian	*Relationship to Patient*	*Date*