# UNIVERSITY HEALTH SERVICES CONSENT FORM

Name:_____ Employee or Student ID:_____

**AUTHORIZATION TO GIVE MEDICAL CARE – CONSENT TO TREATMENT**: I hereby voluntarily consent to outpatient care from University Health Services at the University of Mississippi (UHS) encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the medical staff. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by UHS's medical staff, as is necessary in the medical staff's judgment.

**CONSENT FOR USES & DISCLOSURES**: I hereby consent to UHS to use and disclose my health information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

**NOTIFICATION OF PRIVACY**: I acknowledge that I have been offered a copy of the UHS's Notice of Privacy Practices and Patient Rights.

**NOTICE OF CANCELLATION NO-SHOW & LATE ARRIVAL POLICY:** I acknowledge that if I must cancel my appointment, I must notify UHS at least 1 hour in advance. I understand that if I do not give this proper notice and am a no-show for my appointment, a $20 charge will be placed on my bursar. I understand that if I arrive 10 minutes or more after my scheduled appointment time, I will be rescheduled for another time.

**FINANCIAL POLICIES**: I authorize UHS to file a claim with my insurance carrier for services rendered. I authorize payment of medical benefits by any insurance carrier to either the clinic or myself. I understand that health insurance is a contract between myself and my insurance carrier. UHS will bill my insurance carrier as a courtesy to me. In order to properly bill my insurance carrier, UHS requires that I disclose all insurance information including primary and secondary insurance cards. Failure to provide complete insurance information may result in patient responsibility for the entire bill. I acknowledge that it is the insurance carrier that makes the final determination of my eligibility and benefits. If my insurance carrier pays me directly, I acknowledge that I am responsible for payment and agree to forward the payment to UHS immediately. I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, UHS may refuse to treat me. My signature below indicates that I understand and accept the content of this form.

**NOTICE OF SEPARATE BILLING FOR LABORATORY SERVICES:** In this facility, this clinic uses different reference labs for certain testing, and you may receive a separate bill from them. Please be advised that some insurance companies mandate where your lab tests can be performed. The provider in this facility may be in-network with your insurance company but the reference lab we use may not be. If you have questions as to whether your charges will be managed in this manner, please consult with your insurance company. If you have any questions, please consult with our billing office.

**CONSENT FOR ELECTRONIC COMMUNICATION:** I consent that UHS can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of online communications, provided that these communications comply with privacy, state, and federal regulations. I understand that I can revoke this consent at any time by contacting UHS. If you do not consent to this form of communication, initial here:_____

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Authorized Patient Representative Date Relationship to the Patient

THE UNIVERSITY of MISSISSIPPI
University Health Services

# Individual Notice of Privacy Practices Acknowledgement

I acknowledge that I been offered a copy of University Health Services Notice of Privacy Practices and have either received or declined said copy. I acknowledge and accept the published rights and responsibilities of being a patient of University Health Services.

_____

Print Patient Name

_____ _____

Signature of Patient Date

OR

_____

Signature of Patient Representative
or
Parent/Legal Guardian if Under 18

_____ _____

Signature of Witness Date