UF | Student Health Care Center
UNIVERSITY of FLORIDA

CONSENT AND AUTHORIZATION

PATIENT NAME (LAST, FIRST): _____

UF ID: _____ **VISIT DATE:** _____

Authorization for Medical Care: I hereby authorize the healthcare providers of the University of Florida (UF) Student Health Care Center (SHCC), their agents or consultants ("health care providers"), to perform diagnostic and treatment procedures that, in their judgment, may become necessary while I am a student at UF. I consent to SHCC taking photographs and/or video/audio recordings of me in the course of and related to my Care, and to their use of such photographs or videos and my medical data for educational purposes. **Telemedicine:** I understand and agree that my providers may utilize telemedicine (the electronic communication of medical information) including, but not limited to, videoconferencing, electronic transmission of imaging, and remote monitoring of vital signs as part of my Care. Except in emergency circumstances, my providers will explain the risks and benefits of telemedicine prior to the telemedicine encounter. I understand that I have the right to seek Care elsewhere in lieu of a telemedicine encounter. **Pelvic Examination Consent:** I understand that as a part of my medical care and treatment, a pelvic examination may be performed by my health care practitioner(s). In addition, I understand that a pelvic examination may be performed by a medical student, or any other student receiving training as a health care practitioner.

Release of Medical Information: I understand that the SHCC works in conjunction with SHCC Psychiatry and UF Counseling and Wellness Center (CWC). I authorize the release of information between these entities based on need for diagnosis and treatment. I further authorize release of any information to county, state, or federal public health agencies, as required by law.

I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a healthcare provider in the course of my Care) may be disclosed to employees, officers, agents, and legal representatives of UF, for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation, and mediation) involving UF or other entities.

I understand that I am responsible for further charges incurred and authorize the University Faculty Group Practice and SHCC to release information from my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests) and any other information that may be required to secure payment for charges incurred by me or on my behalf to: (1) any University facility or affiliated provider; (2) the guarantor on my accounts, which includes my parents; and (3) my or my parents' insurance.

Responsibility for Payment: I agree to be personally responsible for payment of any care that is not covered by the University Health Fee*, or my or my parents' insurance, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments. I understand that if the charges are billed to my parents' insurance, my parents could receive a statement from the insurance company regarding the services I received.

*The University Health Fee, paid as part of tuition, covers patient financial responsibility associated with most SHCC office visits (for example, when a medical provider evaluates a sick patient but does not order any tests, procedures or prescriptions), and with telephone or online services initiated by the patient. Patients are financially responsible for items not covered by the health fee; these include, but are not limited to: health insurance premiums; hospital visits; external community providers/facilities; physicals; procedures; X-rays; lab tests; medical equipment; prescriptions; non-prescription medications; vaccinations; massage; and physical therapy.

While SHCC does perform some labs in house, others may be sent to reference labs according to the type of lab and my insurance. I may receive bills from the following reference labs, Quest, LabCorp, or UF Pathology.

I understand if I do not cancel my appointment and do not show, I will be assessed a $25 no show fee.

Agreement to Mediate: In accepting care at the SHCC, I agree that before I file any lawsuit against SHCC or any of its facilities, employees or agents, and/or UF, arising out of the care provided to me by providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third person who has been certified to be a mediator tries to help settle claims. UF will pay the cost of the mediator. I further agree that any mediation must take place in the State of Florida and in the county where my care was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

NOTE: If you would like to communicate with a third party about your current condition(s), please give your healthcare provider contact information and verbal permission. In the event of an emergency, Emergency Contact information will be obtained from the Office of the University Registrar.

NOTICE OF LIMITED LIABILITY The diagnostic and treatment procedures provided by my health care providers is subject to the provisions of Section 768.28, Florida Statutes, which limits recovery for a claim or a judgment by any one person to $200,000, or any claim or judgment, or portion thereof, which, when totaled with all other claims or judgments arising out of the same incident or occurrence, to $300,000.

Signature of Patient/Guardian/Guarantor_____ Date: _____

Printed Name/Relationship to patient: _____ □ Self □ Guardian □Guarantor □ Insured