UNIVERSITY HEALTH SERVICES
UNIVERSITY OF WISCONSIN-MADISON
333 East Campus Mall
Madison, WI 53715-1381
http://www.uhs.wisc.edu

MR#_____
Name_____
BD_____ Gender_____
ID#_____ Date_____

University Health Services (UHS) Information and Consent Form

Consent for Medical Treatment

I voluntarily consent to be treated. This may include routine diagnostic, radiology and laboratory procedures and medication administration by my healthcare provider, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination at UHS. An additional informed participation form is required for mental health treatment.

Consent for COVID-19 Test Results

To protect and prevent the spread of Covid-19 on campus, in the event you test positive, your positive result will be reported to local health officials as legally required.

If you are a student your positive results will be shared with University campus officials with a need to know (e.g., Environment, Health and Safety; University Housing) to ensure that appropriate cleaning of your dorm can be completed and to assist with public health prevention measures on campus, such as contact tracing and isolation

If you are an employee or UW affiliate your positive results will be shared with University campus officials with a need to know (e.g., Environment, Health and Safety; Office of Human Resources; Divisional Disability Representative) to ensure that appropriate cleaning of your work area can be completed and to assist with public health prevention measures on campus, such as contact tracing and isolation.

Patient Rights and Responsibilities

As a patient at UHS, I understand that I have certain rights and responsibilities. A copy of the UHS patient rights is available from any UHS staff member or at www.uhs.wisc.edu.

Confidentiality

UHS takes its commitment to the confidentiality of my patient information very seriously. Confidentiality means that, in general, information contained within my records cannot be disclosed without my consent. However, there are certain exceptions. These exceptions are explained in the UHS Notice of Privacy Practices available www.uhs.wisc.edu. I understand that a copy of the Notice of Privacy Practices is also available to me at the point of service.

Communications

It is UHS' normal practice to communicate with patients through their MyUHS account about health matters, such as the results of a lab test. Sometimes UHS may leave messages on my voicemail. I have the right to request that UHS communicate with me in a different way, and UHS will agree to reasonable requests. To protect confidentiality, UHS does not communicate with patients via e-mail except for appointment reminders. Electronic communications should be sent through MyUHS.

Authorization to Release Information (Applicable to Students Only)

I understand that as part of my care, UHS maintains health records regarding my treatment. As a student, I understand that these records are protected under the Family Educational Rights and Privacy Act (FERPA) and Wisconsin State Law. By signing this form, I authorize University Health Services to use and disclosure my health information to carry out treatment, billing and healthcare operations. I further authorize University Health Services to disclose records to myself.

I may revoke my consent in writing except to the extent that UHS has already made disclosures relying on my prior consent or where disclosure of my information is permitted or required by law. I have the right to refuse to sign this authorization. If I do not sign this consent, UHS may decline to provide treatment.

Payment Information for Students (Applicable to Students Only)
Many services provided to students at UHS are pre-paid by the Student Health Fee. I understand that I will be informed if a health care provider recommends a service or medical item from UHS that is not covered by the Student Health Fee. Payment for this service is my responsibility as the patient. I will receive a Statement of Service from UHS which I may submit to my insurance company. Except for the Student Health Insurance Plan (SHIP), **UHS will not bill insurance, verify insurance coverage, or accept assignment of insurance benefits.** If I intend to seek payment or reimbursement from my insurance, I understand it is my responsibility to verify the terms of my coverage by contacting my insurance provider before services are received**.** UHS is out-of-network for all health insurance plans except the Student Health Insurance Plan (SHIP).

Payment for services is due within 30 days of service. I understand that if my UHS bill is not paid within 60 days, a hold will be placed on my student account and this hold will prevent future class enrollment. After 90 days, in accordance with University policy, any unpaid bill will be forwarded to a collection agency.

Certification
By signing this form or clicking the “I accept” box, I certify that:

- I have read this form, or it has been read to me, and I am satisfied that I understand its contents.
- My questions have been answered to my satisfaction.
- I acknowledge that I have read the UHS Notice of Privacy Practices.
- If I am a student, I authorize University Health Services to use and disclose my medical information to carry out treatment, billing, and healthcare operations.
- I consent to communicate with my UHS provider through MyUHS.
- I consent to treatment at UHS.