CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS & CONDITIONS OF TREATMENT

Name of Patient: ______________________________ Todays Date ____________________
Print Legibly

BYU ID #: ______________________________ Date of Birth: ____________________
MM/DD/YYYY

I hereby consent to the use or disclosure of the above-named Patient's individually identifiable health information ("personal health information" or "PHI") by Brigham Young University Student Health Center, Brigham Young University-Idaho Student Health Center, Brigham Young University-Hawaii Student Health Center, and Missionary Training Center Clinic (collectively "SHC") in order to carry out treatment, payment, or health care operations. The BYU Student Health Center maintains a HIPAA NOTICE OF PRIVACY PRACTICES. The SHC has informed me of the NOTICE OF PRIVACY PRACTICES, which contains a more complete description of the potential uses and disclosures of such information, and I have been given the right to review the NOTICE OF PRIVACY PRACTICES prior to signing this Consent. *Date*_________ *Initials*____

I authorize and direct that the following people may receive PHI concerning any diagnosis or treatment: *Date*_________ *Initials*____

_______________, _______________, _______________, _______________
Name *Relationship* *Name* *Relationship*

_______________, _______________, _______________, _______________
Name *Relationship* *Name* *Relationship*

I retain the right to request that the SHC further restrict how the PHI is used or disclosed to carry out treatment, payment, or health care operations. The SHC is not required to agree to such requested restrictions; however, if the SHC does agree to restrictions that I request, such restrictions are then binding on the SHC.

I understand that, at all times, I retain the right to revoke this Consent. Such revocation must be submitted to the SHC in writing. The revocation shall be effective *except* to the extent that the SHC has already taken action in reliance on the Consent. This authorization may be revoked by contacting BYU Student Health Center, Medical Records, 2102 SHC, Provo, UT 84602, (801) 422-5134.

I further understand that the SHC may refuse to treat Patient if I do not sign this Consent, except to the extent that the SHC is required by law to treat individuals. If I sign this Consent and then revoke this Consent, the SHC has the right to refuse to provide further treatment to Patient as of the time of revocation, except to the extent that the SHC is required by law to treat individuals.

I understand that I may opt out of the SHC patient visit list. If I choose to opt out, the SHC will be unable to provide information to Patient's family, friends, or others. I acknowledge that if I choose to opt out of the SHC patient visit list for this or subsequent visits, it is my responsibility to inform the receptionist.

I have read the foregoing statements and have had the opportunity to ask any questions I may have about them. Such questions have been answered to my satisfaction, and I indicate my understanding of what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

I ALSO hereby agree and give consent for Patient's care at the SHC by the attending clinician and his or her associates, assistants, and designees, as deemed necessary and advisable. Such care may include x-ray examination, laboratory procedures, diagnostic procedures, nursing, counseling, and medical and surgical treatment. In consideration of the medical care and treatment to be rendered to me by the SHC, I agree and consent to the following conditions:

MISSED APPOINTMENT: If Patient arrives late for an appointment requiring rescheduling, or if Patient fails to keep an appointment without calling the SHC to cancel the appointment at least 1 hour prior to the scheduled time for the appointment, then I understand that I may be charged a $10 fee.

MEDICAL RELEASE: I authorize the SHC and any clinician to whom I may be referred for care or treatment to release necessary medical documentation regarding Patient's treatment for the purpose of continuing care. In order to have Patient's PHI released for any other purpose, I understand that a separate Consent MUST be signed and provided to the BYU Student Health Center, Medical Records, 2102 SHC, Provo, UT 84602.

COSTS: I understand that I may inquire about the costs of services before the services are performed.

PAYMENT AND PRIVATE INSURANCE AGREEMENT: I understand and accept my financial obligations to compensate the SHC for medical services provided to Patient. The SHC may not be contracted with some insurance companies. However, I understand that when I bring my insurance card to my appointment, and if the SHC is contracted with my insurance, the SHC will bill my insurance

company. I also understand that all charges will be sent to "MyBYU" financial account, whether my insurance company is contracted with the SHC or not, and that I am ultimately responsible for the payment.

I agree that if all charges I incur are not paid by the due date and if, for the purposes of collecting the amount due, BYU should retain an attorney or collection agency, I will pay all costs of collection including reasonable interest, reasonably attorney's fees, and reasonable collection agency fees, which may be based on a percentage at a maximum of 40% of the debt.

I also agree to allow BYU or its agent to contact me by email or cell phone in an effort to collect the debt. I also authorize BYU or its agent to use automated telephone dialing equipment, and to use artificial or pre-recorded voice messages in their efforts to contact me. Further I understand that I may withdraw my consent for BYU or its agent to use automated telephone dialing equipment or artificial pre-recorded voice messages to contact me by submitting my request to the BYU Collections Office via YMessage or in writing or verbally at A-153 ASB, Provo, UT 84602, (801) 422-6634; or in writing to the applicable agent contacting me on behalf of BYU. Finally, I understand that my delinquent account may be report to one or more of the national credit bureaus.

RESPONSIBLE PARTY INFORMATION *(if different from patient)*:

Name: ______________________________

Relationship to Patient: (circle one) Spouse Father Mother Other: ______________

Mailing Address: __________________________ Apt # ______ City: ____________________

State: __________ Zip: __________

Preferred Phone: ( ) __________________ Date of Birth: _____/_____/_____

Social Sec. No.: - -

Employer: ______________________________ Employer Phone: ( ) ______________________

I, the undersigned, sign this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient.

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Signature of patient, guardian, or authorized representative Date

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Signature of witness Date