STUDENT LIFE
UNIVERSITY HEALTH SERVICE
UNIVERSITY OF MICHIGAN

Patient Name: _____
Date of Birth: _____
U-M ID: _____

Privacy Practices/Patient Agreement Consent-CHILD

Notice of Privacy Practices Acknowledgement:

I hereby acknowledge that I have been offered or received the University Health Service (UHS) Notice of Privacy Practices (*For Notice of Privacy Practice, see www.uofmhealth.org/protecting-your-privacy-hipaa)*

Agreements:

1. **Assignment of Medical Benefits**

Except as barred by any agreement between my insurance company and UHS or by state or federal law, I understand that I will be responsible for my child's co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I assign all rights and benefits to UHS in order to facilitate reimbursement for health care services. I will help UHS follow up on these claims. I further understand and agree that UHS may reach out to other University of Michigan offices, including the Office of Financial Aid, to verify my child's ability or inability to pay costs not covered or paid by insurance or other third party payers.

2**. General Consent to Receive Health Care Services**

I agree for my child to receive health care services such as medical, psychological, nursing and/or other health care, which may include procedures, tests, drugs, and treatment necessary to my child's care. I understand that the University Health Service provides a continuum of care and therefore may contact other healthcare providers and services with the minimum necessary information to facilitate my child's ongoing care, including but not limited to CAPS staff and other University of Michigan healthcare providers, such as those in Psychiatric Emergency Services (PES) if there is a clinical need to know and/or urgent situation. I understand that UHS may provide necessary information about me to other university officials if doing so is needed to prevent or lessen a serious threat to the health or safety of other individuals or the public. I understand that my child may receive care through telehealth services. The limitations of telehealth visits include the possibility of not being able to pick up conditions found during a complete physician exam. There may also be technical difficulties like a lost connection or interruption. I know that my signature provides consent for UHS to share this information as needed and provides permission for these services to contact my child once the physician writes an order. I know that I have a right to consent to or refuse to consent to any future care for my child and to discuss this care. The health care provider will discuss with my child either in person or on line, specific care and/or interventions including procedures, and obtain a specific consent. Invasive procedures and special treatments, such as immunizations, may require additional consents. I know that the practice of medicine is not an exact science and outcomes may be different for each patient.

*** By signing below, I agree that I have read and fully understand the content of this consent form.**

_____ / / _____
Signature of Parent/Legal Guardian Date

_____ / / _____
Printed Name of Parent/Legal Guardian Date

Relationship: ☐ Parent ☐ Legal Guardian

For Health Service Use Only: *Obtained by:* _____ *Role:* _____

Verbal Consent: *Call to:* _____ *Date & time:* _____ *Result:* _____