DUHS HIPAA Consent

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PATIENT RIGHTS

Duquesne University Health Service (DUHS) provides quality health care to all eligible students regardless of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity and expression, disability, or political affiliation. Our patients have the right:

-to be treated in a civil manner with consideration, respect, and courtesy in all interactions
-to have discussions, examinations, and treatments conducted in a private, safe environment
-to an authorized Health Service Staff medical professional chaperone during a medical examination
-to expect that protected health information (PHI) will be kept confidential per Duquesne University, state, and federal regulations and released to a third party only with the patient's written consent or if required by law
-to be informed of the identity and credentials of the health care professional providing services
-to actively participate in decisions concerning their health and the care they receive
-to a clear explanation of diagnosis, prognosis, methods of treatment, and alternatives to treatment
-to a clear explanation of tests ordered, the reason(s) for ordering them, and the benefits /risks of medications dispensed or prescribed
-to ask questions of their health care provider
-to be informed of personal responsibilities for medical treatment, and managing health and wellbeing after treatment
-to choose or change providers (depending on availability) within the Student Health Center (SHC)
-to receive information on patient rights, patient responsibilities, services, hours of operation, and provisions for after-hours care and emergency coverage
-to receive information about and explanation of fees for services and payment policies
-to express concerns directly to the director or any staff member of the health center

PATIENT RESPONSIBILITIES

Duquesne University Health Services (DUHS) is committed to providing quality health care to students. We believe that quality health care is a result of collaboration between the medical provider and patient. Active participation in your own health care is a responsibility that will assure the best outcomes. Responsible actions expected of student-patients include:

- Seeking medical care soon after feeling ill so you do not put others at risk of becoming ill
- Allowing a reasonable amount of time when accessing services and arriving early or on-time for your designated appointment, in consideration of others
- Keeping your appointments, or cancelling/rescheduling as far in advance as possible, so that your appointment time may be given to another patient
- Familiarizing yourself with visit fees, associated laboratory and medication fees, and paying for services rendered at the time of service
- Using self-check-in kiosks with either card-swipe or manual entering of identification
- Having a basic understanding of the benefits of your insurance plan and contacting the member services department of that plan if you have questions
- Acting in a courteous manner, showing respect to health care personnel and other patients by refraining from eating, drinking, and using cell phones while in the health center
- Providing complete information about a health problem or illness to the medical provider, including accurate information about your medical history, allergies, or medications you are taking
- Asking questions to ensure that you understand your illness or problem and the recommended treatment
- Securing prescription medications (in your possession), taking them as directed, and not sharing them with others
- Communicating with your health care provider if a condition worsens or does not follow the expected course
- Taking responsibility for actions and outcomes if you refuse treatment, care, or services or if you do not follow the health care professional's instructions
- Contacting the Director with any concerns about Health Services
- Notifying DUHS staff if you have a living will, health care proxy or power of attorney for health-related issues

PRIVACY ACKNOWLEDGEMENT

Duquesne University Health Services (DUHS) Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. It also provides information on what your rights are regarding your protected health information as outlined by the Health Insurance Portability and Accountability Act of 1996. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by making a request to Duquesne University Health Services. By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practice or have had the opportunity to review the notice.

CONSENT FOR TREATMENT AND PAYMENT AGREEMENT

Duquesne University Health Services will submit a claim to your insurance company, provided that Health Services received all required information necessary to file a claim. Insurance benefits/coverage is a contract between you and your insurance provider. Thus, it is your responsibility to know what your benefits are. Most insurances do not fully cover all of the services provided, and

only cover a portion of services rendered.

Therefore, I give my consent to receive medical services at Duquesne University Health Services during enrollment as a Duquesne University Student. I hereby, approve and authorize release of medical diagnostic information to my insurance provided to process claims for reimbursement of services. I also, authorize payment of benefits directly to Duquesne University Health Services from my carrier.

I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory providing testing.

I agree and understand that I will be responsible for any balances due after my insurance deems what is patient responsibility for services based on my benefit plan. I agree and understand any services that are not billable to my insurance are also my financial responsibility. Duquesne University Health Services will bill services to the student's primary insurance carrier on file. I authorize any unpaid balance to be billed to my student account at the end of the semester.

I am also aware and agree that if I would prefer to use services as a self-pay situation, I will request that at time of visit and will be responsible for payment at the end of visit on the same date of service.

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FROM DUQUESNE UNIVERSITY

This consent only authorizes disclosures of this office visit and related protected health information and/or record(s) on this particular visit. Information on sexually transmitted diseases, acquired immunodeficiency syndrome, human immunodeficiency, behavioral or mental health services, and treatment for alcohol or drug abuse can be in medical records. This information may be released to the following individual(s) or organization: _____

For the purpose of: _____

I understand that I have the right to revoke this authorization at any time and that I must put that request in writing, and present that request to the Privacy Chairman or the Administrator of this entity who will deliver it to the Privacy Chairman. I understand that the revocation will not apply to the information that has already been released, nor to information that is required by law by my insurance company.

This consent for disclosure expires immediately upon completion of this specific action or within thirty (30) days. Further disclosure to other parties by the release is not permitted without the written consent of the patient. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may see or copy the information to be used or disclosed. I understand that once my information is disclosed it may not be protected by the same high confidentiality standards as required by HIPAA and enforced by this entity. I understand that any questions that I have concerning this can be answered by calling this entity's HIPAA Privacy Chairman.

PRINT YOUR LEGAL NAME BELOW TO AUTHORIZE CONSENT FOR SERVICES

Patient Name: _____

Signature: _____

Date: _____