Student Consent for Medical Treatment and Telehealth - Minors

USE ONLY FOR MINOR STUDENTS UNDER THE AGE OF 18

Student Name: _____

Campus ID: _____ Date of Birth: _____

1. CONSENT FOR MEDICAL TREATMENT

I, the undersigned, hereby consent to any and all diagnostic procedures, tests, medical treatment, and hospital care required in the diagnosis of my illness and course of treatment by the provider(s) identified below or their designee, medical staff and other agents, and/or employees of the University of Miami Student Health Service, University of Miami Health System (UHealth), the University of Miami Medical Group (UMMG), and/or the University of Miami (collectively, "University" or the "University of Miami"), including supervised residents and medical students. I recognize that the University of Miami is a teaching and research facility and that my treatment and care will be observed, and in some instances, aided by residents or medical students in their course of training. I am aware that the practice of medicine is not an exactscience and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures, or any other services rendered.

2. COVID-19 SCREENING

By consenting to medical treatment at the University of Miami, including but not limited to COVID-19 testing and treatment, you also acknowledge that the University of Miami may use the information collected through COVID-19 testing and treatment for the purpose of its COVID-19 surveillance program, including to protect the health, safety, and welfare of its students, employees, and faculty or for any other lawful purpose. You also understand and agree that your COVID-19 screening and/or testing information may be shared with the following groups of individuals who have a legitimate educational interest in such information:

- a University contact tracing team,
- University emergency management,
- Your university supervisor(s),
- University leadership,
- other appropriate personnel at the University to evaluate your ability to safely participate in work, housing, academic and other University activities.

You acknowledge that any and all information related to screening for COVID-19 exposure and testing or diagnosis (including answers to questions, materials, or documents), will be disclosed to the University of Miami as set forth above. You may receive communication through email and text message and test results through your private, personal portal in Epic, an electronic medical records management platform used at the University of Miami. We will ask you a series of questions related to your current health status and any new symptoms you may be experiencing. We will also ask you questions related to your exposure or contact with others who may have COVID-19. These questions will be related to your risk of having COVID-19.

It is important to note that, while the University of Miami may confidentially disclose your screening and testing information with appropriate University personnel as described above, these individuals have a legal obligation to maintain your confidentiality. Additionally, where feasible and as determined by the University, the information provided to personnel above will be "de-identified", meaning that your identity will no longer be attributable to any of the COVID-19 information provided.

3. DISCLOSURE OF MEDICAL INFORMATION

a. (Third Party Payers, Guarantors, Physicians & Internal Operations)
By signing this form, I hereby authorize the University to use and release information and/or copies of my medical information as necessary for my treatment, for payment for that treatment and for the health care operations of the University of Miami; including to UHealth, treating physician(s) or other provider(s), guarantor(s) of my accounts, or third party payers for which I have assigned benefits for my treatment and care, and, if requested, to my referring physician(s), or any other healthcare provider(s) responsible for my care. My authorization to the University to use and release information includes information pertaining to psychiatric and/or psychological care, alcohol and/or substance abuse, AIDS or HIV diagnosis, testing and/or treatment for this period of illness as well as medical and other information as necessary for the operations of UHealth or as required to secure payment for charges incurred by me or on my behalf, including a diagnosis of my medical condition.

b. (University-approved business partners under legal and contractual obligation)

By signing this form, I hereby authorize the University to use and release information and/or copies of my medical information to its approved business partners which the University of Miami and University of Miami Student Health Service deem necessary to provide you with and coordinate healthcare services and payment for such services. These business partners are under contractual and legal obligation to keep your medical information confidential and secure.

c. (Health Research)

The University of Miami Student Health Service is part of the University of Miami, which is an academic medical center. As an academic medical center, the University of Miami conducts various types of health research to advance scientific knowledge of and treatment for diseases and other health conditions. By signing this form, I hereby authorize the University to use and release information and/or copies of my medical information for purposes of health research. Your medical information will only be used either in de-identified format (meaning you cannot be reasonably identified from such information) or under certain conditions where a special research committee (called an Institutional Review Board) has authorized such use under special conditions.

4. RELEASE OF LIABILITY FOR LOSS OF PERSONAL PROPERTY

I release the University and the facilities in which services are rendered from all liability resulting from the loss of personal property by theft or negligence of any employee of the University of Miami or of any third party. I agree that I am responsible for any personal property I keep with me in my possession, including, but not limited to electronic equipment, money, eyeglasses, jewelry, or any other personal items.

5. MEDICAL INFORMATION & THE COUNSELING CENTER

I understand that my medical information is confidential except as consented to in this document, where you otherwise authorize such use or disclosure, and where otherwise required by law.
I understand that if I threaten to harm myself, and/or others, the University may be obligated to seek my hospitalization and/or disclose information contained in my medical records. I also authorize the staff at the University of Miami Student Health Service to discuss my case and treatment amongst themselves and to consult the staff at the University of Miami Counseling Center to coordinate care and/or treatment when professionally appropriate and/or medically necessary. **If a student is under 18 years of age and is not legally emancipated, s/he should be aware that the law in most cases allows parents to examine their child's treatment records, unless the physician believes that such a review would be harmful to the client and to his or her treatment.**

6. AUTHORIZATION TO USE & DISCLOSE UHEALTH MEDICAL RECORDS

I authorize the Student Health Service to access my UHealth (University of Miami Health System) medical records including but not limited to the UChart electronic medical record to obtain results of diagnostic testing, consultation reports, vaccinations, and any other information relevant to care provided at the University of Miami Student Health Service and Counseling Center.

7. PAYMENT FOR SERVICES

The University of Miami Student Health Service accepts Cane Card, check and debit or credit card as payment for services. For many insurance plans, we can submit charges to your insurance provider, prior to transferring any unpaid balances to your student account.

Payment of all charges, including any balances remaining after partial payment from your insurance provider, remains your obligation. Claims submitted may be subject to deductibles, co-payment, co-insurance and may be processed by your health plan as "out of network" leading to a lower level of coverage. Any amount not covered by your insurance plan will be your obligation, and balances will be placed on your student account.

It is your responsibility to know and understand your plan coverage, co-payments, deductibles, co-insurance and total out of pocket expenses. Some insurance plans require you to designate one of our physicians as your primary care provider before we can submit charges for reimbursement. If you have an HMO insurance plan, your insurance company may require that you have a referral or pre-authorization to be seen at the University of Miami Student Health Service. In these situations, please contact your insurance company prior to scheduling an appointment to verify benefits and financial responsibility.

I understand and acknowledge by signing this document that I give the University of Miami Student Health Service permission to file a claim to my health insurance carrier for the purpose of payment for services received. I further understand and agree that the Student Health Service may not be a contracted provider with my individual health insurance plan and that I may be responsible for any unpaid balance or for services not covered by my insurance plan. I understand that it is my responsibility to know what coverage I have under my individual plan. I give the University of Miami Student Health Service permission to place these unpaid balances on my student account with the Office of Student Account Services. I am aware that a REGISTRATION HOLD will be placed on my student account for any unpaid balance and that I may be assessed service fees on balances not paid by the due date assigned by the Office of Student Account Services.

8. PUBLIC HEALTH INFORMATION

I understand that certain medical information will be reported to the Miami-Dade County Department of Health according to State of Florida requirements for reporting of notifiable diseases and conditions.

9. TELEHEALTH SERVICES

This document is your consent to receive telehealth services through the University of Miami Student Health Service. Telehealth service is the delivery of healthcare services when the healthcare provider (referred to as Provider in this document) and the student are not in the same physical location/site through the use of various technology.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of identification and imaging data and will include measures to safeguard the data and to safeguard its integrity against intentional or unintentional corruption.

Primary responsibility for your medical care should remain with your local primary care doctor, if you have one, as does your medical record.

To participate in telehealth services, you understand that you will need a computer or tablet device with a camera for video conferencing, speakers or headphones, and a good internet connection or good telephone reception. You will need to be in a private location to ensure your privacy.

Since this may be different than the type of consultation with which you are familiar, it is important that you understand,acknowledge, and agree to the following statements:

*** I understand that I am agreeing to participate in a telehealth encounter that will contain my personal information as well as my medical information.

*** This consent will remain in effect until I withdraw it. I have the right to withdraw my consent to the use of the telehealth services at any time, which I may exercise by providing written notice to the University of Miami Student Health Service. The withdrawal of my consent will prevent me from using the telehealth services but it will not affect my right to future care or treatment should I seek it. Any withdrawal of my consent will be effective upon receipt of the written notice described above, except that such withdrawal will not have any effect on any action taken by a Provider(s) in reliance onthis telehealth consent before the University of Miami Student Health Service received my written notice of withdrawal.

***** I understand that University of Miami Student Health Service can only provide telehealth services to a student who is in the state of Florida at the time of the telehealth encounter.**

*** I understand that there are limitations in the provision of medical care and treatment via telehealth services and that I may not be able to receive a diagnosis and/or treatment through telehealth services for every condition possible.

*** A Provider may determine in his or her sole discretion that my condition is not suitable for diagnosis and/or treatment using the telehealth services, and that I may need to seek medical care and treatment with a specialist or other healthcare provider, outside of the telehealth services.

*** I understand that the provider will be at a different location than me.

*** I understand that it is my responsibility to make conditions or symptoms known to the provider as well as to make arrangements for follow-up care.

*** I voluntarily consent to healthcare services provided which may include review of diagnostic tests, medications, examinations, and consultation on pre- or post- medical or surgical treatments considered necessary for treatment.

*** I will be informed and given the opportunity to verbally consent before additional persons at either my or the provider's site are to be present.

*** I understand that there are risks and consequences from receiving telehealth services, including, but not limitedto, the possibility, despite reasonable efforts on the part of the University of Miami, that the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be accessed by unauthorized persons.

*** I understand that using a form of communication technology other than University of Miami approved telehealth applications may compromise security protocols or cause information transmitted to be insufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the consulting healthcare provider. I understand that such communications may not be included as part of my treatment record.

*** I understand that the University of Miami will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA) and applicable state statutes and regulations, to ensure confidentiality regarding the release of student personal information. No information will be released without my prior approval, as set forth in this consent document, and except as provided by law.

*** Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for representatives of the University of Miami, and/or other providers involved with the provision of telehealth services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s), or to collect any amounts I may owe, the University of Miami, and/or other providers involved with the provision of telehealth services may contact me at the telephone number(s) provided which could result in charges to me by my telephone or internet provider. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as anauto-dialing device, pre-recorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of receiving telehealth services.

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*** If my Provider is concerned about me, loses contact with me, or if I fail to show for a scheduled telehealth service session, I grant permission for University of Miami to contact me by phone or email to check on my well- being.

*** I have been given the opportunity to ask the University of Miami questions my telehealth encounter, security practices, technical specifications, and other related risks.

I certify that I have read or had read and/or had this form explained to me; that I fully understand its contents including the risks and benefits of telehealth services; and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

STUDENT ATTESTATION

I FULLY UNDERSTAND THE ABOVE INFORMATION AND AM NOW SIGNING OF MY OWN FREE WILL.

☐ **Student** ☐ **Parent / Legal Guardian** ☐ **Student Legal Representative**

_____	_____	_____	_____ AM / PM
Signature	Print Name	Date	Time
_____	_____	_____	_____ AM / PM
Provider Signature	Name of Provider Obtaining Consent	Date	Time

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Interpreter's ID / Name