UNIVERSITY HEALTH & COUNSELING
UNIVERSITY OF MICHIGAN

Privacy Practices/Patient Agreement Consent-CHILD

Notice of Privacy Practices Acknowledgement:

I hereby acknowledge that I have been offered or received the University Health & Counseling (UHC) 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 UHC 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 UHC in order to facilitate reimbursement for healthcare services. I will help UHC follow up on these claims. I further understand and agree that UHC 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 healthcare 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 UHC 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. This may include, but is not limited to, Counseling and Psychological Services (CAPS) staff, clinicians, and other external 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 UHC 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 potential for incomplete evaluation of certain conditions that would otherwise require an in-person evaluation with a healthcare provider. There may also be technical difficulties, such as a lost connection or interruption. I know that my signature provides consent for UHC to share this information as needed and provides permission for these services to contact my child once the healthcare provider 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 healthcare provider will discuss with my child, either in person or online, 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:*_____