PATIENT RIGHTS & RESPONSIBILITIES & CONSENT FOR TREATMENT

You have the **RIGHT** to…

1. Be treated with respect, consideration and dignity without regard to race, national origin, age, gender, sexual orientation, religion, political belief, or handicap.
2. Privacy regarding all aspects of your treatment.
3. Request and receive information concerning your diagnosis, evaluation, treatment and prognosis, in easily understandable terms. This includes your right to review your medical record and/or receive a copy of it. When it is medically inadvisable to give such information to you, such as being physically, mentally or emotionally incapacitated, the information will be provided to a person designated by you or to a legally authorized person.
4. Receive enough information to give informed consent before a procedure is performed and when possible, to participate in all decisions affecting your health.
5. Have the opportunity to participate in decisions involving your health care, except when such participation is contraindicated for medical reasons, such as being physically, mentally or emotionally incapacitated.
6. Be informed regarding your treating professional's credentials, record keeping, goals, techniques to be used, limitations of treatment, and to receive a response to any other questions you may have. The right to expect your health care provider to adhere to all ethical standards of his/her profession.
7. Change health care providers if other qualified health care providers are available.
8. Refuse any medical or counseling services and to request and receive information about the potential risks and benefits associated with not receiving care.
9. Have your personal health information held in confidence as protected by state and federal law. This information cannot be shared with anyone outside SHC without your written permission or under circumstances prescribed by law, such as a life threatening situation; court order; reporting of certain communicable diseases and actual or potential abuse of vulnerable individuals; or providing confidential information to authorized officials conducting security investigations under the Patriot Act (which prohibits us from notifying you when a release occurs). Student workers handling your record must meet the same confidentiality standards as staff. Serious breach of confidentiality is grounds for dismissal for students or staff.
10. Receive and review a current copy of our NOTICE OF PRIVACY PRACTICES. It can be found on the SHC web site which is updated as indicated.
11. Reasonable response to your request for services, to offer suggestions for improving services, to file a grievance, information on procedures for filing a grievance and how to make external appeals. Procedures for expressing suggestions, complaints and grievances are posted on our website or are available with the receptionist.
12. Quality health care, health maintenance and health education with an emphasis on prevention.
13. Upon request, we can provide information regarding:
    - Diagnostic and clinical services on-site, our hours, fees, and special preventive and therapeutic services for certain high risk groups
    - Contact information for health care providers when SHC is closed.
    - Our policies on treatment of un-emancipated minors
    - Health education programs
    - Access to in-patient care, dental services, and consultation by specialists.
14. Expect that when we are not open, you will have information on how to access urgent or emergency care.
15. Be informed of continuing health care needs and the right to expect reasonable continuity of care when referrals to other agencies or services are made.
16. Expect SHC to inform you of any plans to engage in research affecting your care, and to give you the right to refuse to participate.
17. Expect SHC to advocate control of environmental problems or factors affecting your health, (e.g. nutrition, sanitation, noise, crowding, safety, stress, etc.)

You have the **RESPONSIBILITY TO…**

take an active role in your own health care by:

- Seeking medical attention promptly
- Providing us complete and accurate information to the best of your ability about your health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities
- Following the treatment plan prescribed by your provider
- Asking about anything you do not understand
- Reporting any significant changes in symptoms or failure to improve.
- Providing a responsible adult to transport you home from our facility and remain with you for 24 hours, if required by the provider
- Informing your provider about any living will, medical power of attorney, or other directives that could affect your care
- Accepting personal financial responsibility for any charges (payable by cash, check, TITANCARD or student account)
- Being respectful of all health care providers and staff, as well as other patients
- Canceling appointments, allowing us to schedule this time with another patient needing services
- Providing useful feedback about services and policies

UNIVERSITY OF WISCONSIN OSHKOSH STUDENT HEALTH CENTER (920)424-2424

CONSENT FOR TREATMENT

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, I acknowledge that the Student Health Center (SHC) has given me a copy if its Notice of Privacy Practices, which explains how my health information will be handled in various situations. I have also been given a chance to discuss my concerns and questions about the privacy of my health information. I understand that if I have any further questions or concerns, I may contact Pamela MacWilliams, UW Oshkosh Student Health Center Director at 920.424.2424 for clarification.

PROMPT SERVICE

SHC always tries to be prompt, but occasionally, appointment delays occur. If you are experiencing an urgent problem, please inform our staff. You may receive services on a same-day appointment basis by calling (920)424-2424 Staff are available by phone and in person to answer your questions. Clinic hours are posted our website at: www.studenthealth.uwosh.edu.

APPOINTMENT REMINDERS

I understand that an automatic UW Oshkosh email reminder will be sent 24 hours prior to my scheduled appointment time.

FINANCIAL RESPONSIBILITY

I understand that I can ask the provider for an estimate of charges prior to the service rendered. I acknowledge that I am responsible to pay for any and all services rendered at SHC. Payment can be made on the day of service by cash, check or Titan Card. Payment if not received on day of service will be charged to your student account. SHC does not bill insurance companies. You can ask for a copy of the Patient Receipt to send to your own insurance company.

NO SHOW CHARGE

I understand that my appointment time is reserved exclusively for me. If I miss or arrive late for an appointment or do not call to cancel an appointment, a no show fee will be charged to my student account

MENTAL HEALTH COUNSELING

If you receive Psychiatry services, your initial session will be devoted to defining your concerns as clearly as possible to determine how our service can best meet your needs. If you miss or do not call to cancel an appointment, the no show fee will be applied to your student account. I agree to follow the treatment plan prescribed by my healthcare provider and will participate in ongoing care.

MEDICAL EMERGENCIES

SHC is not an emergency facility. For a **medical emergency** (threat to life, limb or function) call 911 to access the Winnebago County emergency line. If you have health questions when Student Health is closed, call your own healthcare provider or Mercy Medical Center Urgent Care (920)233-7300 or Aurora Healthcare Walk-in Clinic (920)303-8700. If you have a mental health crisis call the Winnebago County Crisis Intervention Helpline at (920)233-7707.

NOTICE OF RECORD DESTRUCTION POLICY

By signing this form, I acknowledge and accept the following process for the destruction of my medical record. All medical records will be maintained according to state and federal laws. In accordance, it is the policy of the UW Oshkosh Student Health Center to destroy medical records ten years after the last visit. A process for confidential record destruction will be utilized that will ensure that the medical record is destroyed in such a way to prevent any possibility of reconstruction of the information. A "Record Destruction Log" will be maintained which will individually list all medical records destroyed.

ADVANCED DIRECTIVES

The Patient Self Determination Act (PSDA) requires us to provide to you written information about Advanced Directives. A copy of Wisconsin Advanced Directives may be downloaded from www.dhfs.state.wi.us/forms/Advdirectives.

Please sign below, indicating that you have read and understand both sides of this information form. Consent is also given to the care plan as explained to me by my healthcare provider. Upon your request, we will gladly make you a copy of this document to keep for personal reference.

_____	_____	_____
Signature	**ID #**	**Date**
_____	_____	
Print your name legibly	**DOB**	