



UNIVERSITY HEALTH CENTER
 The University of Georgia
 Athens, GA 30602-1755
 (706) 542-1162
 www.uhs.uga.edu

HEALTH FORM FOR SUMMER PROGRAMS

This form is required for treatment at the University Health Center if the participant should become ill or injured while on campus. Please note, there will be charges for services provided by the University Health Center.

NAME _____ SS# _____
 HOME STREET ADDRESS _____ DATE OF BIRTH _____
 CITY, STATE, ZIP CODE _____ GENDER _____
 PROGRAM _____ PHONE (____) _____

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES

I hereby authorize the physicians of the University Health Center, their agents or consultants, to perform diagnostic and treatment procedures on (Name) _____, which, in their judgment, may become necessary while he/she is a participant in (Program) _____ between (Dates) _____ at The University of Georgia. This authorization is valid at local emergency facilities.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I understand that, under The Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). By signing below, I acknowledge that I have read and understand the University Health Center's Notice of Privacy Practices (Notice). It is posted on the University Health Center's website at www.uhs.uga.edu under Information, Medical Records and Confidentiality. The University Health Center reserves the right to change the terms of its Notice of Privacy Practices. If such changes are made, I understand that the University Health Center will post a revised Notice on its web site at www.uhs.uga.edu. I also understand that the University Health Center will provide a Notice to me upon request.

PARTICIPANT (if over 18) _____ DATE _____
 PARENT/GUARDIAN (if under 18) _____ DATE _____

PERSONS TO NOTIFY IN AN EMERGENCY SITUATION

1. Name _____	Relationship _____
Address _____	
Street Number and Name _____	City _____ State _____ Zip Code _____
Work Phone _____	Home Phone _____
Cell Phone _____	E-mail Address _____
2. Name _____	Relationship _____
Address _____	
Street Number and Name _____	City _____ State _____ Zip Code _____
Work Phone _____	Home Phone _____
Cell Phone _____	E-mail Address _____

Date of last Tetanus shot? _____
 Current medications _____
 Allergies to medications? _____
 Chronic medical conditions? _____

PRIMARY INSURANCE INFORMATION Please complete if you wish UHC to file for reimbursement from your insurance company. Providing this information does not guarantee payment of your claim by your insurance company. You are responsible for any charges for services rendered. (Please attach a copy of the front and back of your insurance card.)

Please check appropriate boxes below:

Medical: HMO PPO POS Other Dental Prescription

Policy holder's name: _____

Insured is: Self Parent/Responsible party Third party Your relationship to insured _____

Medical insurance company name: _____

Insurance company street address: _____

Insurance company city, state, zip code: _____

Telephone number: _____

Policy number: _____ Group number: _____

PARENT/RESPONSIBLE PARTY/THIRD PARTY INFORMATION - Name of insured/policy holder: (i.e., parent, step-parent, spouse)

Name: _____ E-mail address: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone number: Home: _____ Work: _____ Cell: _____

Social security number: _____ Date of birth: _____ M F

Marital status: Single Married Divorced Separated Widowed

Place of employment: _____ Full time Part time

Employer address: _____

City: _____ State: _____ Zip code: _____

AUTHORIZATION TO PROCESS INSURANCE CLAIMS

The University Health Center (UHC) will file insurance claims on behalf of patients and clients. The filing of claims does not guarantee either full or partial payment by the insurance company.

The UHC is a participating provider only for the Domestic and International Student Insurance plans available to UGA students. The UHC is not a participating provider for other health insurance plans, including those covering state employees and their dependents. Students and their parents are encouraged to contact their insurance company to request that the UHC be enrolled as a participating provider in their plan.

The UHC Pharmacy is approved to file claims on most insurance plans for prescriptions, whether written by UHC providers or others. Students are urged to check with the UHC Pharmacy staff to see if their policy is covered before attempting to fill prescriptions elsewhere.

I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company which is necessary to process insurance claims for services rendered by this facility. I hereby authorize my insurance company to distribute the payment of my (or my dependents) medical coverage directly to the provider rendering services. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions. I may elect to pay any bill in full in lieu of submitting a claim for insurance reimbursement.

Signature: _____ Date _____
(Participant)

Signature: _____ Date _____
(Parent/guardian if a minor)

For Office Use Only:
Date Received: _____
Received by: _____
Entered by: _____