UCLA Student Health & Counseling

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

1. UCLASHCS: The UCLA Arthur Ashe Student Health and Wellness Center (including U See LA Optometry and Bruin Health Pharmacy) and the Counseling and Psychological Services (UCLASHCS) is part of the University of California. UCLA Health (UCLAH) is part of the University of California and is comprised of its hospital(s), medical center(s), its hospital-based clinics, its Primary Care Network clinics, the UCLA Medical Group; and the David Geffen School of Medicine.

2. MEDICAL CONSENT: I consent to medical treatments or procedures, counseling and psychiatric services, X-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping, laboratory procedures, and hospital services rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. I also consent to my admission to the UCLA Medical Centers if this is necessary for my care. I understand I have the right to receive complete information regarding any treatment, procedure or test, and that I have a right to refuse any treatment procedure or test, and to be informed of the medical consequences of my actions or decisions. I understand that it is my responsibility as a patient to abide by all university policies listed here: www.policies.ucla.edu.

3. TEACHING, RESEARCH AND HEALTHCARE INSTITUTION: The University of California including UCLASHCS and UCLAH, is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care including but are not limited to, breast, pelvic, prostate, and rectal examinations as part of the University's medical education programs. In addition, invasive examinations which are relevant to your procedure may be conducted solely for educational and training purposes by students and other trainees. Some UCLAH faculty are identified by their name badge as "Visiting Professors". These faculty members do not have a California license but are licensed in another state or country. These physicians are permitted to practice medicine in California under a special program developed by the Medical Board of California. I also understand that a University institutional review board approves projects conducted by University researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies, but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

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4. USE OF MEDICAL INFORMATION AND SPECIMENS: I understand that my medical information, photographs, and/or video in any form may be used for other UCLASHCS and UCLAH purposes, such as quality improvement, patient safety and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that UCLASHCS and UCLAH may collect during the course of my treatment and care may be used and shared with researchers. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research. I further understand that

any use of my medical information or Specimens by UCLASHCS and UCLAH or other research institutions will be in accordance with state and federal law, including all laws and regulations governing patient confidentiality, in the manner outlined in the UCLASHCS Notice of Privacy Practices.

6. RELEASE OF MEDICAL INFORMATION: The State of California Information Practices Act requires UCLASHCS and UCLAH to provide the following information to individuals who supply information about themselves. As a patient of UCLASHCS and UCLAH, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UCLASHCS and UCLAH is authorized to maintain this information. As required by UCLASHCS and UCLAH, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage.

UCLASHCS and UCLAH will obtain my written authorization to release information about my medical treatment, counseling and/or psychiatric care, except in those circumstances when UCLASHCS and UCLAH is permitted or required by law to release information (see UCLASHCS and UCLAH Notice of Privacy Practices for a description of the specific circumstances under which UCLASHCS and UCLAH may release this information). For example, UCLASHCS and UCLAH may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, including but not limited to cancer, HIV, tuberculosis, and viral meningitis, UCLASHCS and UCLAH is required by law to report my diagnosis to governmental organizations such as the State Department of Health Services or the Center for Disease Control and Prevention.

7. SHARED ELECTRONIC HEALTH RECORD CONSENT FOR STUDENTS

I understand that UCLASHCS participates in a shared Electronic Health Record system with UCLAH and affiliated hospitals, clinics, and community-based providers. These providers may access my health information within this system only when involved in my treatment. I authorize UCLASHCS to disclose my health records and records considered "education records" under the Family Educational Rights and Privacy Act (FERPA) – to external, licensed healthcare professionals solely for the purpose of providing medical or mental health treatment to me. I understand that once my health information is accessed or maintained by an external healthcare provider, it may be subject to protection under the California Medical Information Act (CMIA) and/or the Health Insurance Portability and Accountability Act (HIPAA).

8. FINANCIAL AGREEMENT: I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay The Regents of the University of California for professional, hospital and clinic

services, including UCLASHCS and UCLAH physician services, in accordance with the regular rates and terms of UCLASHCS and UCLAH. I also agree to pay for other professional services provided at UCLASHCS and UCLAH by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment.

For Students with UC SHIP Insurance: I authorize the UCLASHCS to bill the UC SHIP insurance plan for any services and treatments provided to me. I accept responsibility for payment for all services not covered by UC SHIP, including but not limited to, any visit fees, laboratory testing, procedure, devices, injections, and pharmacy co-payments. These charges will be billed to my university BruinBill student account.

For Students who do not have UC SHIP Insurance: I accept responsibility for payment of all expenses incurred from services provided to me by the UCLASHCS. Some expenses may be covered if I have chosen to purchase BruinCare. I accept responsibility for payment for services that may include, but are not limited to, visit fees, medications, laboratory testing, procedures, devices, injections, x-rays, and supplies. These charges will be billed to my university BruinBill student account. I can obtain an itemized billing statement from UCLASHCS and submit it to my outside insurance carrier for reimbursement consideration.

I understand that I will receive messages and calls on behalf of UCLASHCS and UCLAH, at the numbers provided, including my cell phone number and e-mail address provided during my registration process. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

9. OPEN PAYMENTS DATABASE: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

10. TEXTING CONSENT: I consent to receive text messages related to my relationship with UCLASHCS and UCLAH and partners/affiliates, including updates related to my visits, MyStudentChart account, one-time passcode, billing notifications, prescription reminders, and care management. I understand that texting is not a secure communication method as unencrypted messages could be intercepted. The UCLAH Privacy Policy can be reviewed at

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

https://www.uclahealth.org/privacy-notice. If you have any questions about this Policy, please contact (310) 794-8638. I understand that I can opt-out of SMS messages by texting STOP to respective short code. My opt-out request will generate one final message confirming that I have been unsubscribed. I will no longer receive SMS messages from the short code I opted out from. If I want to join again, I can sign up using MyStudentChart or text HELP to the short code for instructions. If I am experiencing issues with the messaging program I can reply with the keyword HELP for more assistance, or I can get help directly by contacting MyStudentChart Technical Support at (310) 825-4073. I understand that carriers are not liable for delayed or undelivered messages. I understand that message and data rates may apply for any messages sent to me from UCLASHCS and UCLAH from me. I understand that message frequency may vary.

11. E-MAIL CONSENT: I consent to having updates related to my visits, MyStudentChart account, one-time passcode, billing notifications, prescription reminders, and care management sent to me via email with the understanding that I may opt out at any time. I understand that if I email UCLASHCS providers and others involved in my care that I am providing consent for them to respond to me. I understand that email is not a secure communication method as unencrypted messages could be intercepted.

12. VIDEO VISITS CONSENT: Video Visits involve the use of secure audio-visual connection to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering clinical care.

I understand that during my care at UCLASHCS, I may be offered a Video Visit if clinically appropriate. These services may include consultation, diagnosis, treatment recommendation, prescriptions, and/or referral to in-person care if further evaluation is needed. This service is offered to me as a convenience. I understand that I always maintain the option of choosing an in-person appointment if I prefer. I understand that not all services will be clinically appropriate to complete via a video visit and the option will be limited by my provider's discretion. I understand that some parts of the services (e.g., labs, bloodwork, or scans) may be ordered during the visit, which would require me to go in-person to a facility.

Should I agree to a Video Visit, I consent to have my insurance billed for the services and will pay any relevant copays and/or coinsurances.

I understand that during the Video Visit, sensitive medical information may be discussed, and it will be my responsibility to locate myself in a location that ensures privacy to my own level of comfort. I will also be expected to participate in a location that will not cause danger to myself or those around me (such as while driving). If my provider is concerned about my safety, they may terminate the visit.

Video Visits are not appropriate for medical emergencies. If I believe I am having an emergency, I will call 911 and/or go to my nearest emergency room.

13. NURSE PRACTITIONERS: A nurse practitioner is not a physician and surgeon. Patients have the right to see a physician and surgeon under the following circumstances:

- Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started

UCLA Student Health & Counseling

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

- Acute decompensation of a patient
- A problem is not resolving as anticipated
- History, physical, or lab findings are inconsistent with the clinical perspective
- Upon request of the patient

PATIENT RIGHTS NOTICE: (applies to Ashe Student Health patients only)
Agents under a durable power of attorney for health care or your next of kin can review an online copy of the Patient Rights and Responsibilities Notice

ADVANCED DIRECTIVES: An advanced directive is a legal document that allows you to spell out your decisions about end-of-life care ahead of time and indicate who should speak for you if you cannot. It gives you a way to tell your wishes to family, friends and healthcare professionals and to avoid confusion later. You may speak with your provider or a UCLASHCS staff member to understand how to obtain an Advance Directive**.**

I have an Advance Directive for health care (e.g., Power of Attorney for healthcare) ☐ Yes ☐ No
I have provided UCLASHCS or UCLAH with a current copy of my advance directive ☐ Yes ☐ No

If no, it is my responsibility to provide UCLASHCS or UCLAH with a current copy of my advance directive.

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University Hospitals to provide the following information to individuals who supply information about themselves:

The principal purpose for requesting the information is to assure accurate identification and continuity of medical care, and payment therefore, from whatever source. University policy, California Administrative Code Title 22, Division 5, *Licensing and Certification of Health Facilities and Referral Agencies,* and federal statutes authorize our maintenance of this information.

Furnishing all information requested is mandatory unless otherwise noted. Failure to provide such information may affect your medical care and/or any insurance benefits and coverage. This information may be provided: to your referring physician or other health care professionals involved in your medical care; to others to the extent required in connection with collection of accounts or a claim for aid, insurance or medical assistance to which you may be entitled; to University faculty and students for research and educational purposes; and may be released as provided by state and federal law. The privacy of your record will be safeguarded.

Individuals have the right to review their own records, in accordance with the Information Practices Act and University policy. Information on these policies can be obtained from the officials responsible for maintaining the information:

Your medical record is maintained by:
Department Head – Medical Records
UCLA Medical Center/Los Angeles, CA 90095
Phone: (310) 825-6021

Your patient billing information is maintained by:

UCLA Student Health & Counseling

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

Counseling and Psychological Services and
Phone: (310) 825-0768

Arthur Ashe Center/Los Angeles, CA 90095
Phone: (310) 825-4073

PRIVACY – SOCIAL SECURITY NUMBER

The University system of records that requires the social security number was in existence and operating before January 1, 1975, under the authority of the Regents of the University of California. Article IX, Section 9, of the California Constitution. The disclosure is required by law or University procedure in effect prior to that date to verify the identity of the individual.

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your social security number is mandatory. It is used to verify your identity in the medical care, and payment system. Disclosure of the social security number is required pursuant to regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II, of the Social Security Act, as amended.

PRIVACY NOTICE – CANCER REPORTING

If, during your care at UCLASHCS or UCLAH you have cancer diagnosed, UCLASHCS or UCLAH must by State law (Chapter 841, Statutes of 1985) report this to the regional cancer registry. This information is being collected to help identify preventable causes of cancer and includes specific details of the type of cancer and the treatment provided as well as information about you such as your name, age, sex, ethnicity, occupation, religion, address and social security number.

The information reported is confidential under California Health and Safety Codes, Section 211.3 and 211.5, and safeguards are in place throughout the system to ensure that your identity will not be unlawfully revealed. Some cancer patients may be contacted later by the California Department of Health Services or the regional cancer registries as part of their ongoing investigations into the causes of cancer.

NOTICE TO CONSUMERS: Medical doctors, including your physician, are licensed and regulated by the Medical Board of California. For information you may call the Board at (800) 633-2322 or visit its website at http://www.mbc.ca.gov.

I have read, agreed to and received a copy of this Terms and Conditions of Service.

_____ _____ _____ ☐ AM ☐ PM
Signature of Patient or Patient Representative | Date | Time

_____
Relationship of Representative to Patient

_____ _____ _____ ☐ AM ☐ PM
Signature of Witness (Required if patient unable to sign) | Date | Time

_____ _____ _____ ☐ AM ☐ PM
Signature of Interpreter | Date | Time

UCLA Student Health & Counseling

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

_____ _____

Interpreter ID # Language Used

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 7) and Assignment of Benefits (Including Medicare Benefits) (Paragraph 8) set forth above.

_____ _____☐ AM ☐ PM _____

Date Time Financially Responsible Party

_____

Witness