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

HEALTH FORM for 2016 SUMMER CAMPS and PROGRAMS

This form is required for treatment at the University Health Center if the participant should become ill or injured while on campus. FAX to 706-542-4959 prior to camp/program. Please note, there will be charges for services provided by the University Health Center.

NAME _____ DATE OF BIRTH _____

HOME STREET ADDRESS _____

CITY, STATE, ZIP CODE _____ GENDER _____

PROGRAM Leadership Without Limits PHONE (706) 542-6109

PROGRAM CONTACT PERSON Kate Smith PHONE (706) 542-6109

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.

Privacy Practice 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 About UHC, Confidentiality, Patient's Rights and Responsibilities. 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 or significant 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**

Policyholder'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/Policyholder: (i.e., parent, step-parent, spouse)

Name: _____ E-mail Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ M ___ F ___

Marital Status: Single Married Domestic Partner Divorced Separated Widowed

Place of Employment: _____ Full Time Part Time

Employer Address: _____

City: _____ State: _____ Zip Code: _____

AUTHORIZATION TO PROCESS INSURANCE CLAIMS

Patients and Clients are responsible for all charges incurred by themselves or family members for services at the University Health Center (UHC). Examples of charges include lab tests, x-rays, prescriptions, dental procedures, vision procedures, physical therapy, vaccinations, personality testing, after-hours visits, and others. The UHC will file insurance claims on behalf of patients and clients; however, that does not guarantee full or partial payment by insurance companies and students remain responsible for any unpaid balances. The UHC is a participating provider with authorized UGA and University System student health insurance plans, Aetna, BCBS, and basic TRICARE Military healthcare program. Patients and clients are responsible for knowing what their insurance policy covers at the University Health Center. The UHC Pharmacy is contracted with many insurance plans for prescriptions, whether written by UHC or non-UHC providers.

I, the undersigned, have read and understand this information and authorize the release of medical and other necessary information to my insurance company to process claims for services rendered. I hereby authorize my insurance company to distribute payment of my coverage directly to the UHC. I understand that I am responsible for all charges regardless of my insurance benefits and whether incurred by myself or a family member. I authorize the use of this signature on all insurance submissions. I may elect to pay any bill myself in lieu of submitting a claim for insurance reimbursement. I further agree that if UHC refers all or part of the unpaid portion of any bill to an attorney or agency for collection, I am liable for and shall pay UHCôs attorney fees and/or collection agency fees resulting from the referral. I agree to pay all charges and other costs, including attorney fees, that are allowed by federal and state laws and regulations and that are necessary for the collection of these amounts.

Signature: _____ Date _____
(Student)

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

12/03
Revised: 9/22/06, 2/23/2010; 2/3/2011; 2/2012; 2/2013; 2/2016

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