

# Wheaton College

## Student Health Services

### Patient Registration Packet

Welcome to Wheaton College Student Health Services. We desire to provide you quality care that is confidential. Please review this packet which contains the following individual components:

- Notice of Privacy Practice
- Patient Financial Responsibility Form
- Authorization of Release of Information
- Release of Protected Information (optional)

Please read carefully and sign each document if you understand the policy. If you have questions, please ask a Student Health Services staff member.

**Wheaton College**  
**Student Health Services**  
**Notice of Privacy Practices**

**SHS Office Use Only:**

**Name:** \_\_\_\_\_

**ID #** \_\_\_\_\_

Welcome to Wheaton College Student Health Services (SHS). This *Notice of Privacy Practices* describes how SHS may use your PHI (Personal Health Information) within our medical practice and disclose your PHI in order to carry out medical treatment, payment or health care operations. PHI consists of your name, date of birth, address, past and present health information. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. SHS is required by federal and state law to maintain the privacy of your PHI. SHS must comply with the federal law: Family Educational Rights Privacy Act (FERPA) and State privacy laws for active students only. For all other non-students, SHS complies with the relative federal and Illinois state laws for privacy and confidentiality. Your rights and responsibilities are also described in this document. ***We ask that you read this form carefully and ask us any questions you may have about the form or the services SHS provides.*** You will be asked to sign at the end of this section noting that you have read and understand these practices as well as provided consent.

**Use and Disclosures of Personal Health Information**

Your PHI, by law, may be used and disclosed by physicians, nurse practitioners, registered nurses, behavioral health specialists, and administrative staff who are employed or contracted by SHS without your prior consent upon signing this section for the following purposes:

- To share your PHI with other community healthcare providers who are directly involved in your care, such as a referral to a specialist
- To be reviewed for quality assurance and internal quality initiatives to improve healthcare practices
- To obtain payment for services
- To bill or collect payment for services
- To share information with your health plan to determine if the service is eligible for payment
- To Wheaton College Athletic Department if you are an active intercollegiate athlete
- To Student Accounts to bill for services obtained at Student Health Services. (Only charge amounts are provided, not explanation of the services given)
- To insurance companies, in order to obtain pre authorization approval for a test or a type of x-ray, for example.
- Debt referral to collection agencies

**Health Information Exchange: Care Everywhere**

SHS currently uses a community electronic health record (EHR) system, which is utilized by providers and healthcare systems, such as Edwards Hospital, Elmhurst Hospital, Cadence/Northwestern Health System and DuPage Medical Group to name a few. The software program, *EPIC*, provides continuity of medical information to any provider that you may utilize in the immediate community and beyond. Your PHI will be disclosed to these providers when they access EPIC for your direct medical care. This will only be accessed if you seek healthcare from one of these sources. At your initial visit to SHS, you may be asked to sign a “Care Everywhere” consent so that your health information can be viewed by SHS healthcare providers for services received outside of the Northwestern Health System. This “Care Everywhere” system is called a Health Information Exchange (HIE). If you choose not to participate in the HIE, please request a SHS Opt-Out Request Form.

**SHS may use and disclose your PHI without your permission in the following situations:**

1. **Public Health needs:** Within the Dupage County there are certain diseases that must be reported to the public health department to prevent and control disease. We may also notify individuals who may have been exposed to a contagious disease in the effort to decrease the spread.
2. **Legal and law enforcement purposes:** SHS is required by law to report abuse in minor aged students (<18 years). SHS must also comply with legal proceedings which relate to subpoenas or other investigations. Students who desire to press charges for sexual assault, will be required by law to release medical records for review. Please note, SHS is deemed a non-mandatory reporter except in the case of a known perpetual perpetrator.
3. **Minor students:** students under the age of 18 may be required to release certain medical records to their guardian; though this does not include psychotherapy notes.
4. **Coroner's Office:** SHS may disclose PHI to any medical examiner to assist with the identification of cause of death duties.
5. **Worker's compensation:** a student who is working for the College during paid time and experiences an injury due to their work related duties will need to complete a worker's compensation form. Any health information needed to process this form and directly related to the compensation laws may be released.
6. **Harm of self or other:** By FERPA and State mental health laws, health information may be disclosed to non-healthcare professionals if there is deemed a significant need in which you may harm yourself or others, including the greater community.

**Disclosure requiring your written authorization:**

- SHS will not disclose information that is provided to the SHS Behavioral Health Specialist without your specific consent to do so, as these are considered psychotherapy notes.
- To life insurance agencies
- To Wheaton College Registrar, to release basic health information to complete necessary paperwork for incomplete academic status,
- "Protected information" as deemed by the State of Illinois such as: HIV/AIDS status, genetic issues, mental health and substance use, unless a specific release of information has been signed by you and witnessed.
- Coordination of Care: with academic or student support services.

**Other uses or disclosures of your health information:**

1. **Business Associates:** some services (ie. laboratory) are provided through the use of contracted entities. These business associates are provided only the necessary information needed to complete the service. SHS requires all business associates to show proof of how they safeguard your PHI and also notify SHS in case of a breach of privacy.
2. **Appointment reminders:** SHS will contact you if possible 24 to 36 hours prior to your appointment via phone or email. We will only leave a message on your phone if a voice mail box is set up specifically with your name.
3. **Follow up:** Part of providing excellent care is following up with students in how they are currently feeling or future care that they may need. These reminders may be provided via email or phone.

**Your privacy rights:**

- You have the right to obtain a copy of all of your health information records which have been generated by SHS for your care. You must provide a written request to the Director of SHS, explaining what records you need to review. There are some exceptions to records which may be copied and the request may be denied. SHS has the right to charge for any records requested.
- You have the right to adjust your release of information or revoke the release to certain individuals. This must be in writing and only items not yet disclosed will be able to be complied with.
- You have the right to restrict disclosure to certain individuals for certain types of treatment. However, SHS does not need to comply with these requests if they impede the healthcare of another individual or community.
- You have the right to pay for your services in cash and restrict information from being released regarding this specific care paid for in this manner, unless required by law.

- You have the right, after inspection, to amend your PHI. You will need to write the specific details that need to be amended as well as the rationale for the amendment. SHS may deny this request at which time you will have the opportunity to disagree.
- You have the right to a list of individuals, departments, and organizations who have received your PHI. SHS requires 30 days to comply with this request and will charge a reasonable fee for the final product. You may only request information generated within SHS.
- You have the right to receive a notice of breach of your PHI as dictated by the federal government.
- You have the right to complete a formal complaint to the Director of SHS if you have any concerns about these privacy practices or if you feel that your information has been breached.

Contact information:

[Student.Health.Services@wheaton.edu](mailto:Student.Health.Services@wheaton.edu)

Beth Walsh, Interim Director Student Health Services  
630-752-5072

**Your responsibilities:**

You are responsible to provide privacy and courtesy to others by not recording any conversations and taking pictures without a written consent.

**Agreement:**

Your consent, agreement, and understanding to these terms is indicated by your signature

\_\_\_\_\_

**Signature (patient/Guardian)**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Printed Name**

\_\_\_\_\_

**Student ID #**

\*This form will be in effect for the entire time that you are an active student, unless significantly altered or revoked.

**Wheaton College Student Health Services**  
**PATIENT FINANCIAL RESPONSIBILITY**

Thank you for choosing Student Health Services (SHS) as your health care provider. We are committed to providing you affordable and quality care. We ask that you read and sign this form to acknowledge your understanding of our financial policies.

All active students (spouses) are eligible to utilize the services at Student Health Services regardless of their health insurance plan. Nurse visits are free of charge. There are additional charges for services such as allergy injections, vaccinations, wound care, medications, physician and nurse practitioner visits and procedures. These charges are kept well below standard healthcare pricing. All charges will be submitted to your student account. You will be provided an Explanation of Charges, which you can submit to your insurance company for possible reimbursement.

**Your Financial Responsibilities**

1. You, the patient (or patient’s guardian, if a minor) are ultimately responsible for the payment for services that you receive at SHS.
2. If you desire to pay for your visit in cash, you must indicate this at the time of service. If there is an outstanding balance, it will be billed to your student account within 2 weeks of the service date, unless a different payment schedule has been arranged.
3. It is your responsibility to verify in-network insurance coverage and precertification with your health insurance company prior to the completion of services with a community health care provider or diagnostic center.
4. You will be responsible for the payment of additional charges, such as (but are not limited to):
  - Charge for returned check
  - Charge for missed appointments without 24-hours advance notice
  - Charge for extensive phone consultations and /or after-hours phone calls requiring diagnosis, and processing of prescriptions.
  - Charge for the copying and distribution of your medical records.
  - Charges for automatic positive reflex laboratory testing which are billed at the end of the month.
5. You are aware that SHS utilizes other businesses to complete certain services such as the laboratory services provided by Quest Laboratories. SHS is able to bill the patient’s insurance for Quest laboratory tests. You must provide accurate and up to date insurance information prior to testing to SHS if you desire direct insurance billing. The pricing for direct billing is between your insurance company and Quest laboratories. They are not affiliates with SHS and there may be an additional charge if your insurance coverage does not include this laboratory in their network. Please check with your insurance company. Any questions about billing from laboratories are to be resolved by contacting the lab company directly.

**I would like to receive an Explanation of Charges in my CPO box for any services completed at SHS.**

**Agreement**

By my signature below, I acknowledge I have read and understand my financial responsibilities. I understand that I am financially responsible for any charges transferred to my student account and/or not covered by my insurance company. **My signature verifies my understanding:**

\_\_\_\_\_

**Signature (student/guardian)**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Print Name**

\_\_\_\_\_

**Student ID #**

**Wheaton College Student Health Services**  
**Authorization for Release of Information**

I, \_\_\_\_\_, **DOB:** \_\_\_\_\_, **ID#:** \_\_\_\_\_  
 hereby acknowledge receipt and understanding of Wheaton College Student Health Services' (SHS) **Notice of Privacy Practices** \_\_\_\_\_ (Initial), and the **Patient Financial Responsibility Form** \_\_\_\_\_ (Initial).

Please indicate to whom and how Student Health Services can provide financial, medical, and appointment information in the designated area below:

|   |  |
|---|--|
| Name _____<br>Phone _____<br>Relationship _____ | <input type="checkbox"/> Financial<br><input type="checkbox"/> Medical<br><input type="checkbox"/> Appointment Information |
| Name _____<br>Phone _____<br>Relationship _____ | <input type="checkbox"/> Financial<br><input type="checkbox"/> Medical<br><input type="checkbox"/> Appointment Information |
| Name _____<br>Phone _____<br>Relationship _____ | <input type="checkbox"/> Financial<br><input type="checkbox"/> Medical<br><input type="checkbox"/> Appointment Information |

**Do not release any of the above information without my specific request.**

Please indicate if SHS can utilize these forms of communication to disclose personal health information (PHI) such as laboratory results, pharmacy needs, or health education: (Please note, SHS will utilize your my.wheaton email or your phone number to remind you of your appointments. Only discreet information will be noted within the email or phone message).

|   |   |
|---|---|
| <b>E-mail communication:</b> *Your my.wheaton.edu email will be the default email unless otherwise noted.<br>_____      | <input type="checkbox"/> Financial<br><input type="checkbox"/> Medical<br><input type="checkbox"/> Appointment reminder<br><input type="checkbox"/> Breach notification |
| <b>Phone communication:</b> Your cell phone number will be used to verify appointments unless otherwise noted.<br>_____ | <input type="checkbox"/> Financial<br><input type="checkbox"/> Medical<br><input type="checkbox"/> Appointment reminder<br><input type="checkbox"/> Breach notification |

- For email and phone communication, I understand that this is not a secure and encrypted method and I have elected to receive communication in this manner.
- Please note, you will receive an encrypted "My Chart" after your first visit to SHS. We recommend that you use this method of communication to view laboratory results, patient education and to communicate with the healthcare staff at SHS.

**I understand I have the right to revoke this authorization at this time and that my treatment will not be adversely affected by not signing.**

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**Wheaton College Student Health Services**  
**RELEASE OF PROTECTED INFORMATION**

Your health records, maintained by Student Health Services (SHS), may include information regarding drug or alcohol abuse or treatment; HIV/AIDS test results, and/or mental health services. These are considered protected by the State of Illinois and a separate release of information is required.

By signing this form you are specifically authorizing SHS and its physicians, health care professionals, and staff to use and disclose the following type(s) of information:

- *Information about my substance abuse (drugs(s) or alcohol) or related treatment*
- *Information about my mental health or my psychological/psychiatric care or conditions, including diagnoses and treatment recommendations*
- *Information about genetic testing/records*
- *Information about my HIV/AIDS diagnosis and treatment*

**I also allow disclosure to the following individuals identified below:**

|   |   |
|---|---|
| Name _____<br>Phone _____<br>Relationship _____ | <input type="checkbox"/> Genetic<br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Mental Health<br><input type="checkbox"/> Substance Use/Abuse |
| Name _____<br>Phone _____<br>Relationship _____ | <input type="checkbox"/> Genetic<br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Mental Health<br><input type="checkbox"/> Substance Use/Abuse |

|  |                             |            |
|--|-----------------------------|------------|
| <b>Patient/Guardian Name</b>             | <b>Date of Birth</b>        | <b>ID#</b> |
| <b>Witness's Printed Name (REQUIRED)</b> | <b>Signature of Witness</b> |            |
| <b>Date</b>                              |                             |            |

**Date on which Authorization Expires (or within one year)** \_\_\_\_\_

**PLEASE NOTE:** All authorizations for Protected Information must be signed by a witness who can attest to the patient's identity. In addition, the student must identify a date on which this authorization expires; otherwise, the authorization expires within one year of the day it is received by SHS. A student has the right to inspect and copy his or her health information disclosed under the authorization in Section II of this form. SHS may charge a reasonable fee for copying records. If student is ≥ 18 years old, protected information cannot be released until this portion is signed and witnessed.