CENTER FOR HEALTH & COUNSELING
Salt Lake Community College

PATIENT INFORMATION SHEET

Please Print Legibly

Patient Name _____
Last First Middle Initial

The Name You Prefer To Be Called _____ Student I.D. # _____

Date of Birth _____/_____/_____ Your Age Today _____ Gender Expression/Designation: _____

Current Address _____
Street City State Zip Code

Permanent Address _____
Street City State Zip Code

Home Phone # (___) ____-_____ Work Phone # (___) ____-_____ Cell Phone # (___) ____-_____

Which campus do you attend the most? _____ How many credit hours are you taking this semester? _____
Do you have health insurance? Yes___ No___

Emergency contact will be used only in a true emergency. We will not contact this person for past due balances, laboratory results, or any information about your medical treatment.

Emergency Contact Name: _____
Emergency Contact Phone (Work or Home): _____

Date: _____ Reason for appointment:_____
Date: _____ Reason for appointment:_____
Date: _____ Reason for appointment: _____

This clinic has very low prices for laboratory, treatments and vaccines. We will work with you on any balance due. We take payments. Please discuss any problems you have with payments. If there is no contact after several attempts, we will put a hold on your grades and/or transcripts until paid. We try very hard to work with patients who cannot pay at time of service.

All records are held in the strictest confidence. We will not discuss any information about your office visits, lab results or treatments on the phone or via e-mail, unless you have previously verbally (in-person) or in writing given us permission to do so. We will release records to another clinic or provider with a signed release of information form for that clinic or provider.

E-Mail Address (optional) _____ Please check here ☐ if you give your permission for us to contact you via e-mail with test results, appointment reminders, etc.

Please turn to back, read the Conditional Agreement, Sign and Date.

CENTER FOR HEALTH & COUNSELING
Salt Lake Community College

CONDITIONAL AGREEMENT

I understand:

Confidentiality –

1. All information contained in my medical record is confidential and will be treated as such. The Student Health Clinic cannot release any information regarding my medical treatment without my express written consent (release) except as described in 2, or as required by law.
2. The Student Health Clinic may release all or part of my medical record to any insurance company that may be liable for the charges.
3. Any questions will be treated as an appointment for confidential reasons.

Treatment and Services –

1. All SHC providers are subject to the provisions of the Utah Governmental Immunity Act, Section 63-30-1, et seq, UCA 1953 as amended, which controls all procedures and limitations with respect to any claim of liability or malpractice.
    a. All medical care will be provided by, or under the direction of a referring physician, Family Nurse Practitioner, or a medical assistant employed by Salt Lake Community College.
    b. Because the Student Health Clinic may be a teaching center for family nurse practitioners, graduate students may be involved in your care. SLCC students in the medical assisting program and/or the nursing program may also be involved in your care.
2. By seeking medical services at SHC, I give my consent to any reasonable laboratory procedures, and/or medical or surgical treatments performed or ordered by my SHC provider, unless I specifically refuse such services.

Payment for Services and Financial Arrangements –

1. The Student Health Clinic charges for laboratory, certain treatments and procedures, and injections including vaccines.
    a. I am responsible for making full payment at the time services are received.
    b. I agree to make full payment for services at time of service or within 10 days of service.
    c. If not paid within 10 days, any unpaid balance on my account will result in my school records and registration being put on hold until the debt is paid.
2. I may cancel my appointment at SHC up to 24 hours before its scheduled time. If I do not cancel my appointment within this allowed time, I will be considered a "no show". "No show" visits incur a $10.00 fee. .If I incur two "no show" appointments within a semester, I will only be allowed to be seen on a walk-in basis as the schedule allows.

Additional Assistance –

1. With reasonable notice, I may request assistance for a disability or accommodations for hearing impaired.

Complaints or Other Concerns –

1. I understand that I may choose one primary SHC health care provider, and I may change providers or seek a second opinion from another SHC provider, if I so choose.
2. I will openly express any questions or concerns about my care to my health care provider.
3. Continued concerns will be addressed formally with the director Center for Health and Counseling.

I have received a copy of the Student Health Center "Patient Rights and Responsibilities".

I am the person, or I am legally responsible for the patient whose name appears below. I have read this entire document and understand my signature constitutes acceptance of the terms as written.

Name of Patient (Please print full name) Today's Date

Signature of Patient