



# University Health Center

Student Affairs

UNIVERSITY OF GEORGIA

UNIVERSITY HEALTH CENTER

The University of Georgia

Athens, GA 30602-1755

(706) 542-1162

www.uhs.uga.edu

## HEALTH FORM for 2019 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 \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

PROGRAM CONTACT PERSON \_\_\_\_\_ 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.

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](http://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](http://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 most Aetna, Blue Cross Blue Shield (BCBS), Standard Tricare, United Healthcare, Cigna, Humana, Medicaid CMO's and Coventry plans. Patients are responsible for providing current and accurate insurance information and a copy of their current insurance card. Patients 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 UHC's 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; 2017; 2018;2019

For Office Use Only:  
Date Received: \_\_\_\_\_  
Received by: \_\_\_\_\_  
Entered by: \_\_\_\_\_