The FAST Center is staffed by a variety of medical professionals to assist you in addressing your health concerns. We appreciate that you have chosen to entrust us with assisting you in meeting your healthcare needs.

To provide you with the highest quality of care, The FAST Center utilizes an integrated treatment approach. Our clinicians from diverse disciplines work collaboratively as a team to optimize your wellness through seamless prevention and intervention. Your clinician will assist you in deciding which services are most appropriate for you based on your presenting concerns, unique experiences, and goals for treatment.

**Informed Consent for Treatment**

Participating in FAST Center services can result in a number of benefits to you, including improvement or resolution of the specific concerns that led you to seek care. Achieving these benefits requires an open and honest relationship with your clinician and a personal effort to follow through with your treatment plan in order to reach your goals. For example, it will be important for you to take medication as prescribed or follow an agreed upon exercise plan. There are risks associated with any treatment, such as worsening symptoms or allergic reactions to medications. We will work with you during any unexpected treatment outcomes and/or refer you to a higher level of care, if needed.

The FAST Center participates in the teaching mission of the university. Therefore, medical students, residents, nurse practitioner students, nursing students, and medical assistant externs may participate in your care under close supervision of a licensed professional. You have the right to decline if you do not wish for a student to be involved in your care.

You have the right to withdraw from our services at any time. Please consult with your provider or their clinical supervisor if you have any concerns about your care.

**FAST Center Policies:**

**Confidentiality:** All information discussed within office visits is confidential. In most cases, your written and signed authorization is required before information concerning your care can be disclosed to individuals outside of the FAST Center, such as family, partners, or friends. Please be aware that clinicians may be legally required to disclose information in the following circumstances: i) where there is reasonable suspicion of abuse involving a child or senior/vulnerable adult; ii) where there is a reasonable suspicion that a client presents a danger of harm to self or others unless protective measures are taken; and iii) disclosure of records may be required by a court of law in special circumstances. In addition, licensed professionals/supervisors have the right to confer about all aspects of care provided by any clinical students in the FAST Center (e.g. medical students, nurse practitioner students). The FAST Center staff may consult with one another regarding treatment considerations on an as-needed basis. If you have any questions, please ask a staff member.
**Electronic Medical Records:** All protected health information in the electronic medical record is stored in a secure data center and is encrypted. Only authorized staff has access to your health information, and audit logs are monitored to ensure appropriate access. Despite these rigorous precautions, there is a remote chance that a breach could occur. In the unlikely event of such a breach, you will be notified as required by law. Your FAST Center health records will be destroyed 10 years after their receipt or production in accordance with the American Health Information Management Association (AHIMA) guidelines. For minors, health records will be destroyed after the patient reaches the age of majority (18 years) plus 10 years.

**Appointments:** For your convenience, the FAST Center offers same-day and advance appointments. Please call on the day you would like to come in, and we will schedule your appointment. You may also make an appointment using our patient/client portal, UNLV WellnessView. To register on the portal and to make an appointment, please visit https://unlv.medicatconnect.com.

Your appointment time is reserved specifically for you. If you are late for an appointment, your clinician may no longer be available to see you that day, and you may need to reschedule your appointment.

**Emergency Procedure:** Should an emergency or urgent situation arise, the FAST Center has triage clinicians available during our normal hours of operation to assist you. In the event that an emergency or urgent situation occurs outside our hours of operation:

**Call 9-1-1 or go to the nearest emergency room for an emergency**


For any mental health issue call Montevista Hospital at (702) 364-1111 (24 hours) or Spring Mountain Hospital at (702) 873-2400 (24 hours).

The National Suicide Prevention Lifeline can be reached at 1-800-273-8255.

**Minor Patients:** To treat a dependent under the age of 18, the FAST Center must have the written consent of a parent or legal guardian (appointed by a court of law) before any general treatment may begin. The consent must be effective until the student reaches legal age (18 years old) in the state of Nevada. Exemptions include: a life-threatening emergency, treatment for emancipated minors with court supporting documents, treatment of drug abuse or related illness, and examination and treatment of a sexually transmitted infection. There are other situations in which a minor may give consent for services. Please ask to speak to a member of the clinical staff if you would like to discuss your individual situation.

**Communication:** The FAST Center may contact you (by phone, voicemail, email, letter, or through our patient/client portal-UNLV WellnessView) at the contact information you have provided to follow up on care or provide a reminder of an appointment. You are responsible to ensure that your contact information is kept accurate and current. If you would like to register on the patient/client portal, please visit https://medicatconnect.com. Lab results will not be left on a
voicemail unless prior permission has been received. If you have concerns or questions regarding communication, please ask to speak with a staff member.

**Compliments or Complaints:** We welcome and appreciate your feedback to assist us in providing the highest quality of care. If you have compliments, comments, or complaints regarding your care at the FAST Center, please ask to speak with a clinical staff member or the Director of the department. You are also invited to complete an anonymous patient satisfaction survey. The surveys are located in the main lobby. Compliments or complaints may also be reported through our website: [https://www.unlv.edu/srwc/health-center/compliments-complaints](https://www.unlv.edu/srwc/health-center/compliments-complaints).

My signature below indicates that I understand and agree to the above information and policies. I understand that in the event of a life-threatening emergency, this consent may be implied for the time of the emergency.

Print name___________________________________________________________________________________

Signature: ______________________________________________________  Date: ______________________

**For Minors 17 years old and younger:**

Parent or Representative Signature ______________________________________ Date__________________________

Description of Legal Guardianship________________________________ _______Phone number___________________

Print Name of Minor_____________________________________________________________________________________
University of Nevada Las Vegas
Faculty And Staff Treatment (FAST) Center Financial Agreement for Services

I understand that only Academic and Administrative Faculty, Classified and Executive Staff, Letter of Appointment employees, casual employees, and Postdoctoral scholars employed by the University of Nevada, Las Vegas, and the legal dependents of these employees, are eligible to receive medical and pharmaceutical services at the Student Wellness Faculty And Staff Treatment Center. I further understand that I (and/or my dependent) will be required to pay a $25 (effective 09/12/16) copayment for each visit, and that this copayment does not apply to the deductible that is required by any health insurance plan provided by UNLV or any other health insurance plan. I further understand that I am responsible for any additional charges related to diagnostic laboratory tests, medical procedures, medical supplies, copies of medical records, or medications (prescribed or over-the-counter) that I receive in the Student Wellness FAST Center or Pharmacy.

I understand and acknowledge the following:

• Payment is due at the time services are provided.

• I am fully responsible for all charges incurred by my dependents receiving services at the Center or in the Pharmacy.

• A fee will be assessed for returned checks. The prevailing bank rate is assessed for any check returned unpaid by the bank. Any returned check shall be made good within ten (10) days after notification.

• If my account remains delinquent, the Student Wellness Center may send the account to a collection agency, and if so, I will be liable for all collection and litigation costs (34%), in addition to the balance on my account.

• I am responsible for providing accurate address information to the Student Wellness Center. I also acknowledge that failure to provide an accurate mailing address could result in my account becoming delinquent and being sent to a collection agency.

I have read and agree with the above conditions of the FAST Center Financial Agreement for Services.

Patient Signature: __________________________ Date: _________________

Print Patient Name: __________________________ Date of Birth: _________________

FOR DEPENDENTS OF FACULTY OR STAFF

Parent or Representative Signature __________________________ Date: _________________

Description of Legal Relationship: __________________________

Print Name: __________________________ Phone Number: __________________________
Your Information. Your Rights. Our Responsibilities.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:

• Get a copy of your paper or electronic medical record
• Amend your paper or electronic medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

➤ See page 2 for more information on these rights and how to exercise them

You have some choices in the way that we use and share information as we:

• Tell family and friends about your condition
• Provide disaster relief
• Provide mental health care
• Market our services and sell your information
• Raise funds

➤ See page 3 for more information on these choices and how to exercise them

We may use and share your information as we:

• Treat you
• Run our organization
• Bill for your services
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests
• Work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

➤ See pages 3 and 4 for more information on these uses and disclosures
When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 business days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record
- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will need to verify the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting Dr. James Davidson at jamie.davidson@unlv.edu, calling (702) 895-3370, or by writing to Student Wellness Privacy Officer, 4505 S Maryland Parkway, Las Vegas, NV 89154-3020.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Notification of breach
- You have the right to be notified upon a breach of any of your unsecured protected health information.
Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

<table>
<thead>
<tr>
<th>Treat you</th>
<th>Run our organization</th>
<th>Bill for your services</th>
</tr>
</thead>
<tbody>
<tr>
<td>We can use your health information and share it with other professionals who are treating you. We do not share psychotherapy notes without written permission.</td>
<td>We can use and share your health information to run our practice, improve your care, and contact you when necessary.</td>
<td>We can use and share your health information to bill and get payment from health plans or other entities.</td>
</tr>
</tbody>
</table>

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

*Example: We use health information about you to manage your treatment and services.*

*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page
How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

| Help with public health and safety issues | • We can share health information about you for certain situations such as:
| | • Preventing disease
| | • Helping with product recalls
| | • Reporting adverse reactions to medications
| | • Reporting suspected abuse, neglect, or domestic violence
| | • Preventing or reducing a serious threat to anyone’s health or safety
| Do research | • We can use or share your information for health research under certain circumstances.
| Comply with the law | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
| Respond to organ and tissue donation requests | • If you are an organ donor, we can share health information about you with organ procurement organizations.
| Work with a medical examiner or funeral director | • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
| Address workers’ compensation, law enforcement, and other government requests | • We can use or share health information about you:
| | • For workers’ compensation claims
| | • For law enforcement purposes or with a law enforcement official
| | • With health oversight agencies for activities authorized by law
| | • For special government functions such as military, national security, and presidential protective services
| Respond to lawsuits and legal actions | • We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

The Student Health Center, Pharmacy, and Lab; Student Counseling and Psychological Services; and the Student Wellness Business Office.

I acknowledge that I have received this Notice of Privacy Practices, with an effective date of September 23, 2013.

Patient/Client Name: ________________________________________________________________

Signature: _______________________________ Date: ______________

For Students 17 years old and younger:

Parent or Representative
Signature: _______________________________ Date: ______________

Description of Legal Guardianship: ____________________________________________

Phone Number: __________
BILL OF RIGHTS & RESPONSIBILITIES

Your Rights:

Student Wellness strives to provide all patients and clients with the highest quality of health care in a manner that clearly recognizes individual needs and rights. Therefore, patients and clients have a right to:

- Receive treatment without discrimination as to race, color, religion, gender, gender identity, national origin, disability, or sexual orientation.
- Be treated with respect, consideration and dignity.
- Receive care in a clean and safe environment and be provided with appropriate privacy.
- Request treatment by a Student Wellness provider of your choosing and request to change providers at any time if other qualified providers are available.
- Know the name, position, credentials, and function of any Student Wellness staff involved in your care.
- Expect and be afforded confidentiality of all information and records regarding your care.
- Receive information concerning your diagnosis, evaluation, treatment, and prognosis, to the degree known. If it is medically inadvisable to give such information to you, the information will be provided to a person designated by you or to a legally authorized person.
- Participate in all decisions about your treatment, except when such participation is contraindicated for medical reasons.
- Refuse treatment, examination or observation and be told what effect this may have on your health.
- Obtain a copy of your medical record, within a reasonable period of time.
- Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
- Receive all the information you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- Provide feedback or voice a grievance, without fear of reprisal, about the care and services you received (or have failed to receive) and to have Student Wellness respond to you. Grievances or complaints may be provided in person, by telephone, by email, by completing a “Compliments, Complaints, or Concerns”
form in Student Wellness, or by filling out an anonymous survey (paper copy or through the link available on the Student Wellness website). If you request it, a verbal or written response will be provided. If you are not satisfied with the Student Wellness response, you may request assistance from the Director or designee of the department from which you are seeking services. Student Wellness must provide you with department telephone numbers upon request.

- Have reasonable efforts made by Student Wellness staff, when the need arises, to communicate with you in the language you primarily use.

- Understand and use these rights. If for any reason you need help with this, Student Wellness will provide assistance. Please ask a staff member if you need assistance or have any questions.

**Your Responsibilities:**

In order to ensure the effectiveness of Student Wellness services, you and your health care provider must work together to develop and maintain your optimum health. You have the responsibility to:

- Arrive on time for scheduled appointments. If you will not be able to keep a scheduled appointment, please call and cancel, in advance, so that another patient/client may be scheduled in your place.

- Provide your health care provider with complete and accurate information so that she or he will be able to determine the best treatment for you: fill out all forms completely, tell your provider about past and current diagnoses and treatments, such as past illnesses, hospitalizations, medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities; and be as clear as you can about current symptoms, including pain and/or psychological stress.

- Provide correct and complete contact information and keep your contact information updated and accurate with Student Wellness.

- Follow the treatment plan prescribed by your care provider and participate in your care.

- If required by your health care provider, arrange for a responsible adult to transport you home or to another facility from Student Wellness and remain with you for 24 hours or the recommended duration as indicated by your health care provider.

- Be open and honest with your health care provider if you do not understand or cannot comply with instructions you are given.

- Call your health care provider promptly if your condition worsens or does not follow the expected course.
• Meet with your health care provider at least one week before you run out of your current supply of prescription medication.
• Use prescription and over-the-counter medications as directed. You should never share medication prescribed for you with others.
• Treat Student Wellness health care providers and staff, as well as other patients/clients, with courtesy and respect. Please respect others’ right to privacy.
• Inquire about charges and fees prior to approving tests or services.
• Accept personal financial responsibility for any charges. If you are covered under a health insurance policy, you are responsible for any charges not covered by your health insurance plan.
• Pay for services when rendered. If you require assistance, please contact the business office via the Student Wellness front desk.
• Know the coverage provided by your medical insurance policy before making appointments with outside providers or scheduling tests. If you have the UNLV Student Health Insurance Plan and are uncertain about coverage, please contact the Student Wellness Health Insurance Program Officer via the front desk. If you have other insurance, please contact your insurance carrier directly.

My signature indicates that I understand the Student Wellness Bill of Rights and Responsibilities.

Patient/Client Name: ____________________________________________________________

Signature: __________________________________________ Date: ____________________

For Students 17 years old and younger:

Parent or Representative
Signature: __________________________________________ Date: ____________________

Description of Legal Guardianship: ___________________________________________ Phone Number: ____________
UNLV Faculty And Staff Treatment (FAST) Center

Health History Form

Patient Name (print) ____________________________ Date of Birth ____________________________

If patient is a minor, your name and relationship ____________________________

Insurance: CDHP/PPO □ HMO □ None □

What is the best phone number to reach you? ____________________________

What is your current address in the event we need to mail correspondence to you? Address ____________________________

Do you have any allergies/reactions to medications or vaccinations? Yes □ No □

If yes, please list ____________________________

Are you currently taking any medications including prescription, over the counter, vitamins, herbal, or home remedies? If yes, please list ____________________________

Pediatric patients: Are immunizations up to date? All □ Some □ None □

Were you or any relatives ever diagnosed with the following? If yes, check box:

<table>
<thead>
<tr>
<th>Patient Relative</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Heart Disease/Heart Attack</td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>Elevated Cholesterol</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Heart Murmur</td>
<td></td>
</tr>
<tr>
<td>Bleeding or Clotting Disorder</td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
</tr>
<tr>
<td>Cancer (type/site)</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Allergies (seasonal/food)</td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
</tr>
<tr>
<td>Thyroid Disorder</td>
<td></td>
</tr>
<tr>
<td>Hepatitis (type)</td>
<td></td>
</tr>
<tr>
<td>Alcoholism/Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
</tr>
</tbody>
</table>

Have you had any hospitalizations/operations? If yes, please describe and tell us the date. ____________________________

Do you have an Advance Directive or Living Will? Yes □ No □

If Yes, please bring in a copy to Student Wellness to be placed in your confidential patient record. If No, please ask a staff member for more information on creating an Advance Directive, a document in which you specify what actions should be taken for your health if you are no longer able to make decisions based on illness or incapacity.

Do you have any exposure to carcinogens? Yes □ No □

Tobacco use? Yes □ No □ If yes, packs/chew per day ________ for ________ years.

Do you have any exposure to second hand smoke? Yes □ No □

Are you or have you been in a relationship (child/adult) in which you have been emotionally, physically, or sexually abused or threatened? Yes □ No □

Are you in a safe situation at this time? Yes □ No □

Patient Signature: ____________________________ Date: ____________________________

Parent or Representative Signature: ____________________________ Date: ____________________________

Reviewed by Clinical Staff: ____________________________ Rev. March 2017