The Student Wellness Center is comprised of the Student Health Center (SHC), Student Counseling & Psychological Services (CAPS) and the Behavioral Health Team (BHT), which is a joint team within SHC and CAPS. We are staffed by a variety of medical and mental health professionals to assist you in addressing your physical and emotional concerns.

To provide you with the highest quality of care, the Student Wellness Center utilizes an integrated treatment approach. Our clinicians from diverse disciplines work collaboratively as a team to optimize your wellness through 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. There is no charge for office visits with clinicians for currently enrolled UNLV students who have paid their health fee. There may be a charge for additional services as advised by your provider.

Informed Consent for Treatment:

Participating in Student Wellness 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, a better understanding of yourself, enhanced coping skills, and improved interpersonal and academic functioning. 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, follow an agreed upon exercise plan, practice a new skill, or write in a journal. There are risks associated with any treatment, such as worsening symptoms, emotional discomfort, or allergic reactions to medications. We will work with you during unexpected treatment outcomes and/or refer you to a higher level of care with the capability to treat your condition.

The Student Wellness Center participates in the teaching mission of the university. Therefore, professional students in training, such as medical students, doctoral psychology interns, and others, 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.

In order to ensure the highest quality counseling services and to comply with professional training standards, all services provided by practicum counselors at CAPS are video recorded as part of their professional training. These recordings are used only for agency supervisory purposes and kept strictly confidential. All recordings are permanently erased at the end of counseling and supervision. No video recording is performed at the SHC.

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. The Student Wellness Center also reserves the right to deny services when deemed necessary.

Student Wellness Center Policies:

Confidentiality: All information discussed within sessions and office visits is confidential and no clinical records will appear in any academic records or transcripts. In most cases, your written and signed authorization is required before information concerning your care can be disclosed to individuals outside of the Student Wellness Center, such as parents, roommates, friends, partners, and faculty. In the case of a life-threatening emergency, this consent may be implied for the time of the emergency. Please be aware that clinicians within Student Wellness are legally required to disclose information in the following circumstances: i) where there is reasonable suspicion of abuse involving a child or senior/vulnerable adult and ii) where there is reasonable suspicion that a client presents a danger of harm to self or others unless protective measures are taken. Additionally, disclosure of records may be required by a court of law in special circumstances. Furthermore, medical providers are legally required to report the following: i) cancer, ii) burns, iii) communicable disease, iv) epilepsy, and v) non-accidental injury related to a knife or firearm. In addition, licensed professionals/ supervisors have the right to confer about all aspects of care and counseling provided by graduate students at the Student Wellness Center (e.g., graduate students, medical students, nurse practitioner students).
In order to provide quality whole-person care, certain health information will be shared among Student Wellness staff. Specifically, mental health professionals will have access to your mental health and medical records. Medical professionals will have access to your behavioral health records which includes psychiatric records and those of behavioral health providers who work at the SHC, and limited access to CAPS records that include: diagnoses, medications, hospitalizations, risk assessments, screening tools, treatment status including level of care and community referrals, and treatment consents and authorizations. All other treatment information obtained by CAPS will be held in the strictest confidence unless a student specifically signs a separate written release of information. 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 Student Wellness Center health and counseling 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 and counseling records will be destroyed after the patient reaches the age of majority (18 years) plus 10 years.

**Treatment:** Staff members of the Student Wellness Center desire to see every student function at the highest level possible. To achieve this, the Student Wellness Center uses a variety of assessment techniques, such as face-to-face communication with a care provider, laboratory studies, questionnaires, etc. Based on these assessments, students will be offered services most appropriate to their needs. For example, many students benefit from our primary care services for preventive medical care such as immunizations and yearly physicals to treatment of acute and chronic diseases. Other services include behavioral health care which is a type of mental health care that aims to address your emotional, behavioral, and/or physical concerns within the medical clinic. Some students benefit from more traditional outpatient mental health services delivered by CAPS. Should students present with issues that are beyond the level of care of CAPS, SHC or BHT, staff will assist students with community referrals.

**Appointments:** Appointments are available by calling the SHC or CAPS. Patients of the SHC and the Registered Dietitian 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](https://unlv.medicatconnect.com).

Since the scheduling of an appointment is a reservation of time specifically for you, the failure to cancel a same-day appointment prior to the start of that appointment time or to cancel an advance appointment without 24-hours advance notice will result in a $25.00 late cancellation/no-show charge. The $25.00 late cancellation/no-show fee will be charged to your Student Wellness Center account if your appointment is missed at the SHC, CAPS, BHT or with the Registered Dietitian. If you arrive late for an appointment, you may need to reschedule. You may also be charged a late cancellation/no-show fee if you arrive late and miss your appointment time. You may appeal this fee within 30 calendar days of the appointment date when charged in error. If you miss or fail to cancel an appointment two times within a semester, you may be referred off campus for further services at your expense.

**Emergency Procedures:** Should an emergency or urgent situation arise, the Student Wellness 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 of our business hours:

- **Call 9-1-1 or go to the nearest emergency room for an emergency**
  OR
- **For medical concerns:** For non-emergency questions or issues, students may call UNLV Family Medicine at 702-992-6888. UNLV Students with CHP Consolidated Health Plan (Cigna Network) may also call the 24-hour Nurse Advice Line (Ask Mayo Clinic) at 844-886-2896 (toll free).
- **For psychological concerns:** Call the Southern Nevada Adult Mental Health Services 702-486-6000 (M-F 8-5 pm, no insurance necessary) or Desert Parkway Behavioral Healthcare Hospital (24 hrs) at 702-776-3500 or 855-776-8330 (toll free) or Montevista Hospital 702-364-1111 (24 hrs).
- **National Suicide Prevention Lifeline:** 1-800-273-8255.
**Consent for Treatment of Students who are Minors:** To treat a student under the age of 18, the Student Wellness Center must have the signed consent of a parent or legal guardian (appointed by a court of law) on this Informed Consent for Treatment before any services may begin. Services offered in the Student Wellness Center include, but are not limited to, medical services, such as physical examinations, injections (including vaccinations and other medications such as antibiotics), laboratory testing including phlebotomy (blood draw), intravenous (IV) hydration and medications, prescriptions, in-office procedures, such as suturing (stitches) of lacerations, counseling and psychiatric services. Services are provided by health care and mental health professionals and may be provided to the minor without the parent or legal guardian present. If a parent or legal guardian is not present with the minor student in the Student Wellness Center to sign this Informed Consent for Treatment, it must be signed by the parent or legal guardian and notarized. This Informed Consent for Treatment is effective until the student reaches the age of majority (18 years old) in the state of Nevada. However, this Informed Consent for Treatment may be withdrawn at any time, in writing, by the parent or legal guardian prior to the student reaching the age of majority (18 years old). After the Informed Consent for Treatment is signed by a parent or legal guardian, if additional informed consent forms are needed in the future during the course of treatment (such as for a vaccination or in-office procedure), the minor may give informed consent, in writing, as long as the minor demonstrates his/her understanding of the nature and purpose of the proposed treatment, procedure and/or examination, risks and benefits, and its likely outcome. There are other situations in the State of Nevada in which a minor may give informed consent. Please ask to speak to a member of the clinical staff if you would like to discuss your individual situation. By signing this Informed Consent for Treatment, the parent or legal guardian authorizes the Student Wellness Center of the University of Nevada, Las Vegas, to provide medical, counseling and psychiatric services deemed advisable and rendered under the supervision of a licensed health professional. It is understood that this authorization is given in advance of any diagnosis and treatment. Exemptions to the need for parent or legal guardian signed consent in the State of Nevada include: 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.

**Potential Applicants for CAPS Training Program:** Students who wish to apply to CAPS training program should be aware that receiving services from CAPS may delay their entry to the training program. In our efforts to avoid potential complications involved with multiple relationships, students are prohibited from becoming a CAPS trainee while they are receiving clinical services at CAPS. There must be a minimum of a 6-month, or one semester, waiting period between the date of termination of CAPS services and the beginning of a practicum/internship at CAPS.

**Communication:** The Student Wellness Center may contact you (by phone, voicemail, email, letter, text message, 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 with the Student Wellness Center. If you would like to register on the patient/client portal, please visit [https://unlv.medicatconnect.com](https://unlv.medicatconnect.com). If you would like to opt out of receiving important notifications (e.g. appointment reminders and confirmations) via text message, please access the Forms section of the patient/client portal and complete the Text Message Notification Preference Form. 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 Student Wellness Center, please ask to speak with a clinical staff member or the supervisor of the department. You are also invited to complete an anonymous student satisfaction survey or comment card. The surveys and/or comment cards are located on each floor of the Student Wellness Center. Compliments or complaints may also be reported through our website: [https://www.unlv.edu/srwc/health-center/student-services](https://www.unlv.edu/srwc/health-center/student-services).

**Electronic Signature:** Student Wellness uses electronic signatures. I understand and agree that, by typing my name and last four digits of my NSHE number, these represent my electronic signature on Student Wellness documents. I also understand that my electronic signature is legally binding in all respects as a written signature would be, and I consent to the use of electronic signatures within Student Wellness.
Account No. ____________________

Typing my first name, last name, and the last four digits of my NSHE # indicates that I understand and give consent to the above information and policies.

My signature indicates that I understand and give consent to the above information and policies.

Print name: ___________________________________________________

Signature:_____________________________________________________

Date: __________________

For Students 17 years old and younger:

Parent or Representative
Signature:_____________________________________________________

Date: __________________

Print Name of Parent or Representative
Phone Number: ____________________________________________

Print Student Name:___________________________________________
Release of Information within the Student Wellness Center

I understand that the Student Wellness Center staff uses a collaborative care approach to provide optimal care, and this requires staff to communicate various aspects of my care amongst team members. I understand that current and existing information is shared amongst the Student Wellness Center staff when it is clinically relevant to my care and/or safety. Specifically, I agree to have mental health professionals access both my mental health and medical records. I further agree to have medical professionals access my behavioral health records which include psychiatric records and those of behavioral health providers who work at the SHC. Additionally, I agree to allow medical professionals to have limited access to my treatment records at CAPS that only includes: diagnoses, medications, hospitalizations, risk assessments, screening tools, treatment status including level of care and community referrals, and treatment consents and authorizations. I understand that all other treatment information obtained by CAPS will be held in the strictest confidence unless a student specifically signs a separate written release of information. If you have any questions, please ask a staff member. I further understand that no information is released outside of the Student Wellness Center unless allowable under FERPA or HIPAA without a prior written and signed release.

My signature below indicates that I understand and give consent to the above release of information:

Print name: __________________________________________

Signature: ____________________________ Date: ________________

For Students 17 years old and younger:

Parent or Representative
Signature: ____________________________ Date: ________________

Print Name of Parent or Representative: ____________________________ Phone Number: ____________________________

Print Student Name: ____________________________
University of Nevada Las Vegas

Student Wellness Center Agreement for Services

Student Health Center and Student Counseling and Psychological Services

I understand that only registered, enrolled and matriculating students are eligible to receive medical, pharmaceutical, and counseling services at the Student Wellness Center. I also understand that the health fee assessed as part of my registration fees does not cover the cost of all services provided at the Student Wellness Center. I further understand that I am responsible for charges related to diagnostic laboratory tests, medical procedures, medical supplies, copies of medical records, psychological assessments or medications (prescribed or over-the-counter) that I receive in the Student Wellness Center. I understand and acknowledge the following:

Payment is expected at time of services

- The Student Wellness Center will automatically place my university account on registration hold until charges are paid in full. Services from any member institution of the Nevada System of Higher Education will be denied according to the University of Nevada, Las Vegas and the Nevada Board of Regents policy. This hold will not permit a student having a delinquent account to receive transcripts of academic records, diploma, certificate or report of semester grades.

- Students with an outstanding balance may still use the Student Wellness Center services, but may not be able to incur any further charges at the Student Wellness Center. In these cases, the student may be referred to an off campus lab or an off campus pharmacy.

- If I am unable to make a full payment at the time of service, I agree to set up payment arrangements and sign a payment plan agreement form.

- I understand that I am responsible for paying the charge(s) in full if the student health insurance plan denies any or all payments for services received at the Student Wellness Center.

- If my account remains delinquent, the Student Wellness Center may send the account to a collection agency in accordance with Board of Regents policy, and if so, I will be liable for all collection and litigation costs.

- The Student Wellness Center is not responsible for the care or charges incurred off campus. It is my responsibility to make financial arrangements with off-campus provider(s).

- The Student Wellness Center may withhold any check made payable to me by the University of Nevada, Las Vegas and will apply said check to my unpaid balance.

- 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 to the student or suspension or disenrollment procedures may be instituted.

- I understand that I am responsible for providing accurate contact information to the Student Wellness Center. I also understand that without accurate contact information, my account could become delinquent and may be sent to a collection agency.

I have read and agreed with the above conditions of the Student Wellness Center Financial Agreement.

Patient Signature: ____________________________                  Today’s Date: ____________________________
Print Patient Name: ____________________________                  Date of Birth: ____________________________

FOR STUDENTS 17 YEARS OLD AND YOUNGER

Parent or Representative Signature ____________________________                  Date: ____________________________
Description of Legal Guardianship: ______________________________________________________
Print Name: ____________________________                  Phone No. ____________________________

Rev 08/2019
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

Notice of Privacy Practices • Page 1
Your Rights

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.

Treat you

• 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.

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

Run our organization

• We can use and share your health information to run our practice, improve your care, and contact you when necessary.

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

Bill for your services

• We can use and share your health information to bill and get payment from health plans or other entities.

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](http://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: ________
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 your provider 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 or seek emergency care 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. Only take medication that has been prescribed to you and never share your prescribed medications with others. Consult the pharmacy or your prescriber regarding the safe disposal of unused medication.

- Treat Student Wellness staff, as well as other patients/clients, with courtesy and respect.

- Respect others’ right to privacy.

- Inquire about charges and fees prior to approving tests or services.

- Know the coverage provided by your medical insurance policy before making appointments or scheduling tests. If you have the UNLV Student Health Insurance Plan and are uncertain about coverage, contact the Student Wellness Health Insurance Program Officer via the front desk. If you have another insurance plan, contact your insurance carrier directly with questions.

- 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.
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: _____________
STUDENT WELLNESS CENTER
CONSENT WITNESS / NOTARIAL SIGNATURE PAGE

This page acknowledges parent/legal guardian signatures on the following documents:

- Student Wellness Center Informed Consent for Treatment
- Release of Information within Student Wellness
- Student Wellness Center Agreement for Services
- Student Wellness Center Notice of Privacy Practices (NPP)
- Student Wellness Center Bill of Rights and Responsibilities

________________________________________________________________________
Student Name

________________________________________________________________________
Parent/Legal Guardian Name (please print)

________________________________________________________________________
Address

________________________________________________________________________
Parent/Legal Guardian Signature

________________________________________________________________________
Student Wellness Staff Member Witness Signature

OR

Notary Public (if not witnessed by Student Wellness Staff Member)

State of __________________________

County of __________________________

This instrument was acknowledged before me on ________________________, 20______

by __________________________

(name of parent/legal guardian)

________________________________________________________________________
Signature of Notarial Officer