

**TREATMENT AGREEMENT
STUDENT HEALTH SERVICES AT THE UNIVERSITY OF KANSAS**

CONSENT TO TREATMENT

1. I hereby consent to such health care as may be deemed necessary by the providers in Student Health Services (SHS), University of Kansas, Lawrence, KS, including x-ray examination, lab tests, administration of medications, and any other diagnostic or therapeutic treatments.
2. I understand that under some circumstances, an additional lab test (called a "reflex test") may be necessary due to an initial lab result and that I am consenting to such tests as part of the standard of care. (This reflex test is usually done without the need for a return visit or additional specimen.) My provider will explain when these tests may be needed.
3. I understand that SHS is a teaching health facility and that students and residents acting under the supervision of licensed clinical staff may be involved in my care. I understand that I may decline service by the student or resident.

GENERAL CONDITIONS FOR TREATMENT BY STUDENT HEALTH SERVICES

4. I understand that I should fully participate in my care by asking any questions about my condition or treatment.
5. I understand that SHS is not responsible for loss or damage to clothing, jewelry or other valuables in my possession.
6. I acknowledge that the use of any video capturing devices (cameras, cell phones, etc.) by other than authorized personnel for official business is prohibited.
7. I understand that if I have tests or services performed at SHS which are ordered by an outside provider, the reports on those services will be sent to the ordering provider and will be included in my SHS medical record. I further understand that it is my responsibility to follow-up with the outside provider concerning those results.
8. I understand that treatment / services will not be provided while I am using a cell phone.

INSURANCE ASSIGNMENT

9. I hereby assign all benefits payable under the terms of my insurance policy/healthcare coverage to SHS, and I authorize payment directly to SHS for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I understand that if my healthcare coverage changes, I am to notify SHS Business Office.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

10. I understand that if I am enrolled as a part-time student or otherwise had part or all of my Health Fee waived I will be charged the unpaid amount of the Health Fee in order to receive patient care.
11. I understand that SHS does not contract with all insurance companies and it is my responsibility to know if my insurance plan provides coverage for SHS services or requires a referral or pre-approval for such services.
12. Further, I understand that SHS is not a contracting provider for and cannot bill Medicare, Medicaid, or Healthwave. If I have these types of government healthcare benefits, I am responsible for paying all SHS charges and it is my responsibility to seek reimbursement from these programs.
13. I understand that I am financially responsible to SHS for any charges, co-pays and deductibles not covered by my insurance company/health plan. And, I understand that if I do not pay my bill within 120 days of my date of service, my overdue account will be sent to the University's Bursar for collection.
14. If I do not want my insurance company/health plan billed or a statement sent for charges, it is my obligation to immediately advise the SHS Business Office. I understand that I may address any questions concerning my charges, coverage, billing or payments, to the SHS Business Office.
15. I understand that there may be a charge for appointments scheduled during the time period known as "After Hours" and this will be explained to me if I should ever need such an appointment time.
16. I understand if I make an appointment and then fail to keep the appointment without notifying SHS I will be assessed a "Did Not Keep Appointment" (DNKA) fee.

A copy of this document shall be as valid as the original.

_____ Date: _____ KU ID# _____
Print Patient Name

_____ Relationship to Patient
Signature (Patient, Agent or Representative)

_____ Patient Label:
Print Name of Agent or Representative

Original to Medical Record - Copy to Patient

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02-25-09 THE UNIVERSITY OF KANSAS