CONSENT FOR HEALTHCARE SERVICES

I, the undersigned patient, agree to the following:

1. **Scope of Available Services.** I have read the brochure information and/or online information for the Loyola University of Chicago Wellness Center ("LUC WC") and have been informed of and understand the scope of the services offered to me, the patient, by the LUC WC.

2. **Consent to Treat.** I consent to medical and counseling treatment and services, diagnostic procedures and administration of medications deemed necessary and appropriate to treat my condition or illness. I consent to the administration of vaccines mandated by Illinois state law or recommended by the Centers for Disease Control ("CDC"), including vaccinations for Tetanus, Diphtheria, Pertussis, Measles, Mumps, Rubella, and Influenza, unless medically contraindicated. I understand, consent and agree that treatment may be provided by Physicians, Nurse Practitioners, Registered Nurses, Registered Dietitians, Psychiatrists, Psychologists, Licensed Clinical Social Workers and support staff who are employees of or provide services to Loyola University of Chicago. Graduate students in training may, under the supervision of appropriate personnel, participate in my treatment and care. Outside lab services may be provided through LUC WC. Electronic Health Record ("HER") will be used and the information in the EHR will be available to appropriate providers in the WC. I understand that my treating providers will explain why treatment, counseling services, tests or procedures are necessary and they will review common risks, benefits, and alternatives with me. I also understand I have the right to refuse any treatment, procedure, or medications deemed medically necessary by my treating provider. I understand that I may revoke my consent at any time. This consent is voluntary and not mandatory.

3. **Use and Disclosure of Patient Information.** I have read the LUC WC “Confidentiality Agreement.” I understand, consent and agree that the LUC WC may receive, use and disclose information concerning my care, prescription medications, and health care, for evaluation, treatment, payment, and health care operations purposes including but not limited to the disclosures described in the Confidentiality Agreement and to lab, medical, nursing, and mental health providers in order to facilitate my healthcare. I consent to the release of my immunization records to LUC LOCUS account.

4. **Confidentiality Provision for the Patient.**
   (a) Except for as allowed in the “Use and Disclosure of Patient Information” section described above, or in the “Confidentiality Agreement,” or in the “Assignment of Benefits” section below, information about my healthcare will not be given to anyone outside of LUC WC unless I give explicit permission to do so, or as required by law. This means the LUC WC will not talk about me to my parents/guardians, teachers, police, or anyone else unless I give them permission to do so, or unless required by law.
(b) The following are examples of additional exceptions in which the LUC WC may have to talk to specific adults in order to protect me, the patient:
   1. An injury or accident happens on school property;
   2. I share that I am being physically or sexually abused;
   3. I share that I have a plan to do harm to myself or someone else; or
   4. I have a life threatening condition.

   For these exceptions the LUC WC will make every attempt to talk with me, the patient, first before they talk to anyone else.

   (c) Just as the staff at the LUC WC agrees to protect my confidentiality; I agree to respect the confidentiality of all other students/patients that I may see while at the LUC WC. This means that if I see another Patient at the LUC WC and/or I hear information about someone else that may be personal, I agree to keep that information to myself and not discuss it with anyone else.

5. **Treating Providers Not Available at All Times.** I understand that LUC WC will not have treating providers available at all times. When the LUC WC is not available or in the event of a significant medical event or emergency, I may be advised to proceed to the nearest Emergency Department or Urgent Care Facility.

6. **Charges.** I understand I am responsible for all charges associated with medicine received, procedures done, or tests done at the LUC WC. I understand the LUC WC does not submit bills to my insurance.

**Student:** I voluntarily consent to receiving medical and counseling services as deemed necessary by LUC WC professional staff. I am granting consent for the duration of time that I am a patient and seek services at LUC WC. I can withdraw my consent in writing at any time.

Name of Student: _____________________________ Date_________________Age__________
Signature:______________________________________________________________________

If you are 17 or under, your consent form will be reviewed with you with your provider.