**CONSENT FOR HEALTHCARE SERVICES**

**(Adult)**

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 (“LUC”) Wellness Center (the “LUC WC”) and have been informed of and understand the scope of the healthcare services offered to me, the patient, by the LUC WC, whether in-person or via telehealth.
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, Influenza and COVID-19/Coronavirus Disease (“COVID-19”), unless medically contraindicated or for religious reasons. I understand, consent and agree that treatment may be provided by Physicians, Physician’s Assistants, Nurse Practitioners, Registered Nurses, Registered Dietitians, Psychiatrists, Psychologists, Licensed Clinical Social Workers, support staff who are employees of or provide services to LUC and graduate students in training (under the supervision of appropriate personnel) (collectively, “LUC WC Providers”). Outside lab services may be provided through contractors retained by the LUC WC. Electronic Health Record (“EHR”) will be used and the information in the EHR will be available to appropriate LUC WC Providers and to any other person or party to whom I consent. I understand that LUC WC 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 LUC WC Providers. 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 understand, consent and agree that the LUC WC may receive, use and disclose information concerning my care, prescription medications, test results and health care, for evaluation, treatment, payment and health care operations purposes including but not limited to the disclosures described in this consent, disclosures to lab, medical, nursing and mental health providers in order to facilitate my healthcare and disclosures to appropriate applicable international, federal, state, and local governments, departments, agencies and public health authorities as may be required, permitted or otherwise allowed by law. I consent to the release of my immunization and vaccination records to the LUC LOCUS account. In addition, as part of the multidisciplinary services offered to me at the LUC WC, LUC WC Providers may consult with other LUC WC Providers. Because the LUC WC is in an academic setting, clinical psychology students, nursing students, social work students or other students who are doing a part of their clinical practicum in the LUC WC, along with their clinical faculty, may have access to my record as a part of their professional clinical experience. LUC departments and units involved with LUC WC billing will know that I have obtained service but not the nature of that service. Outside referral labs may need diagnostic information about me in order to process my lab tests. These disclosures are a part of regular business operations at the LUC WC.

Further, I consent to disclosure by LUC and the others set forth in this paragraph of my identifiable health information related to any tests results, diagnosis for or vaccination for COVID-19 or other communicable virus or disease (“Other Communicable Disease” and together with COVID-19, “Communicable Diseases”) to other departments and units in LUC and applicable LUC employees, agents and contractors, including without limitation LUC WC, Residence Life, Campus Safety, Facilities, Housekeeping, Dining Services and Dean of Students, and to applicable international, federal, state, and local governments, departments and agencies based on applicable international, federal, state, and local public health and safety laws, rules, regulations, guidance, policies, directives and plans, as amended, supplemented, updated and replaced from time to time (“Public Health Requirements”). The purpose of this consent is to assist in accessing and evaluating Communicable Disease results for the health, safety and welfare of the LUC community and others, for compliance with Public Health Requirements and for follow-up purposes, including without limitation quarantine, exposure evaluation and contact tracing purposes.

In addition to the foregoing, I have consented to and opted-in to authorize, allow and permit LUC WC to share and disclose my immunization and vaccination records (including without limitation my COVID-19 immunization and vaccine records) with the State of Illinois through the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE).

1. **Confidentiality Provision for the Patient.**
	1. Except as required by law, as set forth in this consent, as set forth in any Wellness Center Advocate Consent to Disclose Confidential Information or as I otherwise give explicit permission to do so, information about my healthcare will not be given to anyone outside of the LUC WC. This means the LUC WC will not talk about me to my parents/guardians, teachers, police or anyone else, except as required by law, as set forth in this consent, as set forth in any Wellness Center Advocate Consent to Disclose Confidential Information or as I otherwise give explicit permission to do so.
	2. The following are examples of additional exceptions in which the LUC WC may have to talk to specific persons in order to protect me, the patient: (1) If I report my imminent intent to seriously injure or kill myself or another. Disclosure will be made to protect me or others. (2) If I disclose current child abuse, Illinois state law requires that this be reported to the Department of Children and Family Services. (3) A civil or criminal proceeding which results in a subpoena or court order for disclosure of information about my physical or mental health treatment. The LUC WC might have to disclose some information about me to comply with the subpoena or court order. For these exceptions the LUC WC will make every attempt to talk with me, the patient, first before they talk to anyone else.
	3. Just as the LUC WC Providers agree to protect my confidentiality, I will respect the confidentiality of all other patients that I may see while in the LUC WC. This means that if I see another patient in 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.
	4. I have the right to review my medical or psychiatric record with LUC WC Providers and make a copy of my records.
2. **Treating Providers Not Available at All Times.** I understand that the LUC WC will not have LUC WC 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.
3. **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.
4. **Telehealth Services**. I am informed about, understand, and knowingly acknowledge and agree to certain risks, consequences and limitations associated with the use of Telehealth Services. I have read and understand and agree to the following information about Telehealth Services and all my questions have been answered.
	1. *General.* Telehealth Services, as used in this consent, may refer to counseling sessions or medical visits that occur via telephone or videoconference (whether via a smart phone with videoconferencing capability or by tablet or computer, using an authorized, non-public facing videoconferencing technology, as described below). Telehealth Services are offered to improve access to counseling and medical visits when physical distance or other significant barriers make face-to-face, campus-based counseling and medical visits infeasible. The meaning and scope of Telehealth Services is subject to applicable federal and Illinoi laws, rules, regulations and orders in effect and as amended from time to time, including the Illinois Telehealth Act.
	2. *Efficacy.* The efficacy of Telehealth Services may be less than that of in-person services, and the results of Telehealth Services cannot be guarantee or assured. Moreover, Telehealth Services may not be the best choice or an appropriate means of providing service to certain persons and for a number of reasons including, but not limited to: persons presenting a heightened risk of harm to oneself or others; a patient’s lack of access to, or the LUC WC Provider’s or patient’s difficulty with, communications technology; significant communications service disruptions; the need for an in-person physical assessment to diagnose or treat a medical problem; or the need for more intensive, personal services. In such cases, the LUC WC Providers will help establish referrals to the appropriate services.
	3. *Medical Telehealth Services.* With respect to medical Telehealth Services visits, during the Telehealth Services consultation:
		1. Details of my medical history, examinations, diagnostic services and results, and tests will be discussed with LUC WC Providers through the use of interactive video, audio and telecommunication technology.
		2. A physical examination of me may take place.
		3. The LUC WC will not make video, audio or photo recordings of my Telehealth Services visit, but please be aware that the operator of the telephone or videoconference platform used for Telehealth Services may be able to hear, observe or have a backup copy of Telehealth Services communications.
		4. Conditions that include minor illnesses that include cough/bronchitis, ear infections, earaches, heartburn, indigestion, mouth/oral conditions, nausea, vomiting, diarrhea, pink eye, sties, sinus infections, sore/strep throats, minor injuries, skin conditions, urinary tract infections, vaginal discharge and vaginitis will be treated at the discretion of the LUC WC Providers.
		5. Any medical/surgical condition or conditions that are perceived inappropriate for a Telehealth Services consultation with the LUC WC will be given appropriate community referrals to medical providers and/or specialists outside of the LUC WC for in-person evaluation.
	4. *Telehealth Services Risks.* I understand the following potential risks, consequences and limitations of Telehealth Services:
		1. Telehealth Services are not a substitute for face-to-face counseling or medical appointments. It is an alternative form of counseling and medical consultation with certain inherent limitations.
		2. Telehealth Services have potential benefits, but there are risks associated with telephone and videoconferencing that differ from in-person sessions, such as the risk of diminished privacy and the possible disclosure of confidential information.
		3. Telehealth Services normally will not be appropriate if I am having a medical emergency, psychiatric crisis, acute psychosis or suicidal or homicidal thoughts.
		4. Telehealth Services may be ineffective to fully communicate visual, verbal and non-verbal cues, which may increase the likelihood of the LUC WC Provider and patient misunderstanding each other.
		5. Telehealth Services may have disruptions or delays in the service and quality of the technology used.
		6. I agree that I will only use Telehealth Services with a secure internet or cellular connection. I agree that I will not use public/free Wi-Fi that is accessible without a password.
		7. Security protocols associated with the non-public facing telephone or video technology could fail and my confidential information could be accessed by unauthorized persons. I agree that I will install all security updates recommended by LUC for the telephone or videoconferencing platform that I will be using for Telehealth Services.
	5. *Back-Up Plan.* The use of Telehealth Services also requires a back-up plan in case of technology failure, and, therefore, I agree to the following:
		1. The most reliable backup is a phone. I acknowledge that I must always have a phone available and make sure that LUC WC Provider knows the phone number.
		2. If either party gets disconnected from a Telehealth Services session, this will end the session, and both parties will try to restart the session. If they cannot do so within five minutes, I agree that the LUC WC Provider will call me at the number that I supplied on my patient information form and for Telehealth Services counseling sessions.
		3. If the LUC WC Provider is concerned that I may be having a medical or mental health emergency, I authorize the LUC WC Provider to call my emergency personal contact person listed in this consent and, if necessary, the law enforcement contact in my area.
	6. *Teleconferencing.* When utilizing Telehealth Services, I consent to the LUC WC Providers’ use of standard Zoom teleconferencing software (not Zoom Healthcare) with Apple Facetime as a back-up teleconferencing option. LUC WC Providers will engage in Telehealth Services visits and sessions only from a private location where I will not be heard or interrupted. When receiving Telehealth Services, it is also required that I:
		1. Only engage in sessions when I am physically in the state of Illinois, which is where LUC WC Providers are licensed. The LUC WC Provider will confirm this each session.
		2. Engage in sessions only from a private location where I will not be overheard or interrupted.
		3. Use my own smartphone, tablet or computer.
		4. Ensure that my smartphone, tablet or computer has updated operating and anti-virus software.
		5. Do not record any sessions.
5. **Emergency Contact.**
	1. If I am ever experiencing a mental health crisis or medical or other emergency, I will call 911 or go to my nearest emergency room.
	2. If I need to contact the LUC WC for a mental health crisis and cannot reach my normal LUC WC Provider, I can also call 773-508-2530 and press option 3 to speak to a LUC WC Provider urgently when the LUC WC is closed.
	3. In the event I am unable to reach LUC WC Provider or the LUC WC, I can also contact the following non-LUC-affiliated crisis response resources: 24-hour Suicide Prevention & Crisis Line (916) 368-3111, or Lifeline 1-800-273-8255. I may also contact the crisis text line: <https://www.crisistextline.org/>, text HOME to 741741 (24 hours).
	4. So that LUC WC is able to get me help in the case of an emergency and for my safety, the following are important and necessary. By signing this consent, I am acknowledging that I understand and agree to the following: If LUC WC is concerned about me and loses contact with me (e.g., I fail to show for a scheduled counseling videoconference, I don’t respond to our follow-up attempts, etc.), LUC WC will contact me by phone to check on my well-being. In addition, if LUC WC is uncertain of my safety or the safety of others, by signing this consent, I authorize LUC WC to contact the following emergency contact (e.g., a close personal contact such as a parent, spouse, life partner, sibling, or roommate) or emergency services in my area in order to ensure my safety.

Personal contact:

 Name Relationship Phone

**Patient**: I voluntarily consent to receiving medical and counseling services as deemed necessary by LUC WC Providers and to the types of disclosures that are contemplated in this consent. I am granting consent for the duration of time that I am a patient and seek services at the LUC WC. I give informed consent to use both in-person and Telehealth Services in my care.

Name of Patient: Date: Age:

Signature: