



Patient Demographic Form Please PRINT

Patient Name: _____ Nickname/AKA: _____
Date of Birth: _____ Sex: _____
Longwood Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Cell #: _____ Work #: _____
Language (other than English): _____ Race: _____ Ethnicity: _____
Email address: _____ Employer: _____
Spouse/Parent: _____ Phone #: _____
Emergency Contact: _____ Phone #: _____
Health Insurance: Yes _____ No _____

INSURANCE INFORMATION

Ins Co Name: _____ Policy/ Member ID #: _____
Patient Relation to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____
Policy Holder: _____ Sex: _____
Address: _____ City: _____ Zip Code: _____
Home #: _____ Date of Birth: _____
Employer: _____

SECONDARY INSURANCE

Ins Co Name: _____ Policy/ Member ID #: _____
Patient Relation to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____
Policy Holder: _____ Sex: _____
Address: _____ City: _____ Zip Code: _____
Home #: _____ Date of Birth: _____
Employer: _____

Diagnostic Testing: We recommend that you call your insurance company to be informed of your benefits for any diagnostic test that The Student Health Center may order for you. You should inquire if pre-certification is needed. If so, you will need to contact our office one week prior to your scheduled procedure to avoid claim denial.

Financial Policy: To ensure accurate claim filing, please give your most current insurance card to our front office to be copied. Potomac Healthcare Solutions, LLC participates with most managed care plans. We will bill your insurance company in compliance with the guidelines of our contract. If you do not have health insurance, please indicate above. Random audits may be completed to ensure the accuracy of reported information.

I hereby authorize Potomac Healthcare Solutions, LLC to provide me with medical treatment. I understand and agree that I am responsible for all fees not covered by the Student Health Fee or by my insurance company. I hereby authorize the release of any medical information necessary to file a claim with my insurance company. I understand that any refusal or misrepresentation of my insurance coverage may result in a balance for services rendered and a hold may be placed on my university account as a result of nonpayment.

Patient/Responsible Party Signature

Date



PRIVACY POLICY

**STUDENT HEALTH & WELLNESS CENTER
LONGWOOD UNIVERSITY**

Acknowledgement of receipt of the Notice of Privacy Practices

I understand and have been provided with the Notice of Privacy Practices that provides a detailed description of medical information uses and disclosures.

I understand that I have the right to review the notice prior to signing this acknowledgment form.

I understand that the organization reserves the right to change their notice and practices. The change will be posted in the Health and Wellness Center and available to me on the Longwood web site.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Potomac Healthcare Solutions is not required to agree to the restrictions requested.

I understand that I may revoke this acknowledgment in writing, except to the extent that the organization has already taken action in the reliance thereon.

Signature of Patient or Legal Representative

Date

If representative, define the relationship to the patient. _____



NAME: _____ DATE OF BIRTH: _____
 Last First Middle

PERSONAL HISTORY:

Drug Allergies: _____

Operations/ Serious Injuries: _____

Current Medications: _____

PERSONAL HISTORY – Check if a condition applies to you (past or present)

<input type="checkbox"/> ADD/ ADHD	<input type="checkbox"/> Depression	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Gastrointestinal Disorder	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sexually Transmitted Infection
<input type="checkbox"/> Concussion	<input type="checkbox"/> Kidney Infection/ Stone	<input type="checkbox"/> Thyroid Trouble
		<input type="checkbox"/> Visual Impairment

FAMILY HISTORY- Check if condition exist in immediate family (parents, grandparents, siblings)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Stroke	<input type="checkbox"/> Sudden Death	<input type="checkbox"/> Ulcer

Students 18 years old or older

I hereby authorize the physician/ clinicians of Longwood University Student Health Center to examine, test, and treat me as they may deem advisable. There shall be no release of information to any person or agency without prior written agreement by me, unless required by law.

Student Signature _____ Date _____

STUDENT RIGHTS INCLUDE:

1. The right to humane care and treatment.
2. The right to competent treatment.
3. The right to accurate information.
4. The right to confidentiality regarding disclosures and records.
5. The right to information regarding the scope and availability of service.
6. The right to information regarding fees for services.
7. The right to full information regarding appropriate channels for expressing grievances and making evaluations.
8. The right to know organizational policies regarding experimental research without jeopardizing access to care.

STUDENT HEALTH CENTER PERSONNEL MAY REASONABLY EXPECT STUDENTS:

1. To be honest in providing information to Student Health Center personnel. Failure to provide honest and full information can result in improper evaluation.
2. To ask questions to insure appropriate comprehension of their illness, plan of care, and to appropriately express one's concerns, needs, and feelings.
3. To avail themselves of educational opportunities offered through the Student Health Center, and employ knowledge and experiences gained towards developing a healthy lifestyle and towards modifying the factors adversely affecting health status.
4. To show respect and to be courteous to Student Health Center personnel as well as fellow student subscribers at each encounter.
5. To utilize the grievance process when a problem exists regarding care received or at any time one believes their rights have been violated.
6. To come to appointments on time or cancel/reschedule as far in advance as possible, so that the time may be given to someone else.
7. To abide by Student Health Center policies and State Laws regarding immunizations and health record requirements.
8. To not give medications prescribed for you to others.
9. To communicate with your health provider if your condition worsens or does not follow the expected course.

By signing below, I affirm that I have read and understand the above rights and responsibilities.

Student Signature _____ **Date** _____