LONGWOOD UNIVERSITY

STUDENT HEALTH CENTER
HEALTH HISTORY and
RIGHTS & RESPONSIBILITIES

Potomac Healthcare Solutions

NAME: _____ DATE OF BIRTH: _____
Last First Middle

PERSONAL HISTORY:

Drug Allergies: _____

Operations/ Serious Injuries: _____

Current Medications: _____

Previous medical provider _____ Phone _____

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

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

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

____ Allergies	____ Anemia	____ Asthma	____ Cancer
____ Diabetes	____ Heart Disease	____ Hypertension	____ Lung Disease
____ Mental Illness	____ Stroke	____ Sudden Death	____ 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 _____

Revised 5/16

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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 is 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 _____

LONGWOOD UNIVERSITY

Potomac Healthcare Solutions™

Patient Demographic Form Please PRINT

Patient Name: _____

Nick Name: _____ Date of Birth: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Language (other than English): _____ Race: _____ Ethnicity: _____

Email address: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Insurance? Yes_____ No_____ PCP _____

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 University 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 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.

_____ _____

Patient/Responsible party signature Date

LONGWOOD UNIVERSITY

Potomac Healthcare Solutions™

PRIVACY POLICY

LONGWOOD UNIVERSITY HEALTH SERVICES

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 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. _____

LONGWOOD UNIVERSITY

Potomac Healthcare Solutions™

LONGWOOD UNIVERSITY HEALTH CENTER

106 Midtown Ave, Farmville, VA. 23901

434-395-2102 Fax 434-395-2783

2 Hour Cancellation & "No Show" Policy

As a participant at Longwood University Health Center (LUHC), it is your responsibility to keep record of your scheduled appointment. If you are unable to make a scheduled appointment, we request that you cancel or reschedule at a minimum of 2 hours in advance. You can cancel or reschedule your appointment by (a) calling 434-395-2102 and speaking to a staff member or by leaving a message, (b) (students only) by canceling your appointment on the Student Health web portal, or (c) coming to LUHC at 106 Midtown in the Landings Complex.

A ***No Show*** is when a patient does not show for a scheduled appointment without cancelling or rescheduling the appointment.

If a patient establishes a pattern of cancellations or rescheduled appointment and/or no shows, they will receive a letter, email, secure message via the portal (students only) and/or a phone call from LUHC asking them to make an appointment with the Director before services can resume. If the pattern continues, then there will be a fee of $25.00 charged to the patients account for each reoccurrence.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

LONGWOOD UNIVERSITY

Potomac Healthcare Solutions™

LONGWOOD UNIVERSITY HEALTH CENTER
106 Midtown Ave, Farmville, VA. 23901
434-395-2102 Fax 434-395-2783

Notice of "Deemed Consent" for HIV, HBV and HCV Testing and Lab work consent form

As a health care provider, we are required by 32.1-45.1 of the code of Virginia (1950) as amended, to give you the following notice.

1. If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with Human Immunodeficiency Virus ("HIV", the "AIDS" virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

2. If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with Human Immunodeficiency Virus ("HIV", the "AIDS" virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

3. I understand I have the opportunity to discuss my need for lab work and/or other procedures with a clinician and understand that I am responsible for any payment associated with lab work, x-rays or other procedures ordered today. I wish to bill lab work to:

- ❑ Insurance company (I understand that I will be responsible for any copay or getting a referral if necessary)
- ❑ My home address
- ❑ My campus address (for students)

Signature _____ date _____

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