TREATMENT AGREEMENT & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Information

Patient Name:______________________________ Date of Birth:____________________

USC ID:____________________________

CONSENT FOR TREATMENT/ CARE:

I hereby authorize any medical or mental health treatment for myself that may be advised or recommended by Student Health Services (SHS) @ UofSC. I am aware that the practices of medicine and psychology are not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations, procedures, or analysis.

ACKNOWLEDGEMENT:

I attest that SHS has provided me with a copy of its Notice of Privacy Practices to review. The Notice describes how medical information about me may be used and disclosed and how I can gain access to this information. I understand that it is the responsibility of this office to provide me with a copy of its Notice on the first services encounter after August 25, 2013. If my first date of service with this office was due to an emergency, I understand that it is the office's responsibility to provide me with this Notice and obtain my signature as acknowledgement of receipt as soon as possible following the emergency.

CHECK ALL THAT ARE TRUE:

- ☐ I have reviewed UHS Notice of Privacy Practices.
- ☐ I understand that if I have concerns or questions regarding the privacy of my health information, I may ask a health care provider or affiliate.

____________________	____________________	____________
Patient/Legal Representative Signature	If signor is not the patient, state relationship	Date

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UHS INTERNAL STAFF USE ONLY

COMPLETE IF ACKNOWLEDGEMENT FORM IS NOT SIGNED:

1. Was the patient given a copy of the Notice of Privacy Practices?
   - ☐ **Yes**
   - ☐ **No**
2. If the form is not signed, explain why and your efforts to obtain the patient's signature:

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____________________	____________________	____________
Staff Signature	Print Your Name & Title	Date