General Consent and Acknowledgement Form

Patient Name: _____

Date of Birth: _____

Notice of Privacy Practices

You have received services from one of the University of Delaware's health care providers, collectively, "UD Health". You have a right to know how UD Health protects your personal information. We describe these practices on our Notice of Privacy Practices, which we have provided to you.

(Additional copies of the Notice of Privacy Practices are available at any of our UD Health locations. You may also obtain a copy by sending a written request to the UD Health's Privacy Officer, 112 Hullihen Hall, Newark, DE 19716. Please refer to UD Health's Notice of Privacy Practices for more information about your privacy rights. If you believe your privacy rights have been violated, you may file a complaint with the UD Health's Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with UD Health's Privacy Officer, write to Privacy Officer, University of Delaware, 112 Hullihen Hall, Newark, DE 19716. All complaints must be submitted in writing. UD Health will not penalize you for filing a complaint.)

Please verify that you have received a copy of our Notice of Privacy Practices.

Printed Patient Name: _____

Signature: _____ **Date**: _____

If not signed by the person receiving services, please indicate your relationship/authority to sign on this person's behalf.

_____

Consent for Treatment

I consent to services that my provider feels are medically necessary for health care treatment and diagnostic procedures provided by UD Health clinics and its practitioners, clinicians, and therapists. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at UD Health. I understand that I can withdraw my consent at any time.

I agree to be contacted via email or SMS with information pertaining to my visit including patient portal invitation, patient surveys, appointment or checkup reminders or new services that relate to me or my family. I understand that I can withdraw this consent at any time.

I authorize payment of medical benefits to UD Health practitioners, clinicians and therapists for services rendered.

Patient Name: _____

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Financial Policy

I have received and understand UD Health's financial disclosure form and I agree to its terms. I also understand and agree that such terms may be amended by the practice occasionally. We will issue a revised Financial Disclosure Form which will contain the changes.

Consent for Alternate person to bring Minor Child/Dependent/Care Giver to Appointment

I understand that as the Parent/Guardian, I must bring my child to the first appointment with a UD Health provider, in order to give a complete medical history. Following the first appointment, I give permission for the following individual(s) to bring my child to UD Health for treatment. I understand that by giving permission for this individual(s) to bring my child to their appointment, the individual(s) is fully permitted to consent to treatment recommended by UD Health.

Alternate individual that may bring child/dependent/care partner to UD Health for Treatment

Name	**Relationship**
_____	_____
_____	_____

Consent for minor to receive medical care without an accompanying adult. This consent only applies to minors age 16 or older and shall be in effect for: _____Date(s): _____

___Indefinitely, until revoked in writing

Consent to Release Information

In order for any family members/care givers to receive any medical information, you must provide consent.

If you wish to have any individuals, be able to receive medical information, diagnostic test results and/or financial information, please list below. These individuals may NOT consent to any procedure for you as the patient. You may revoke your consent at any time, except where we have already made disclosures based on your prior consent.

Yes: Initials_____ No_____

If yes, please list:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Date of Birth: _____

Cancellations, Late Patients and No Show

UD Health aims to offer excellent patient care and services. In order to make the most of the time a provider can be with you and reduce your wait time, we have a standard policy for cancellations, late patients, and no shows. By initialing below, you acknowledge our practices and agree to follow our policies.

Cancellations: We require 24 hours notice for any cancellations.

Late: You will be considered late if you arrive 10 minutes or more after your scheduled appointment time. There may be times where your appointment will need to be rescheduled if you go over this time frame.

No Show: If you do not arrive or let us know about not being able to attend your scheduled appointment time, you may risk your ability to schedule with UD Health.

Research:

UD Health strives to improve patient care and results by participating in multiple research studies. Our improvement in patient care depends on patients that qualify to participate in studies. If you are a good candidate for a study, you may be contacted by our Research team to be screened for the study. Agreeing to be contacted **DOES NOT** mean that you will be enrolled in research.

Photographing and Videotaping:

UD Health, LLC may photograph, film, videotape, audiotape, or store all or a portion of my treatment. Recordings may include images and/or voices of anyone who participates in my evaluation or treatment during my appointment. I understand that UD Health, LLC may use these photographs, film, videotape or audiotape for evaluation and treatment as well as for the educational purposes of University of Delaware students, quality assessment and clinical activities or for any other health care operations at UD Health, LLC. This consent includes storing of the recordings for possible future research studies that I may be eligible to participate.

Forms

A charge may apply for forms such as physical, disability and FMLA, to be completed outside of normal appointment times. The charge for completion is $20.00 per form. Please let us know if you need forms to be completed, so we can schedule correctly. There is no charge for forms completed during your normal appointment time.

I certify that I have read, understand, and agree to all terms and conditions outlined above. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction.

Signature: _____Date: _____ Time: _____