CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS AND ACKNOWLEDGEMENT OF RECEIPT OF UNIVERSITY’S NOTICE OF PRIVACY PRACTICES

Welcome to Carolina Nursing Associates of the UNC-Chapel Hill School of Nursing Faculty Practice (the “Practice”). This consent and acknowledgement document contains important information about our professional services and business practices, and information about the Health Insurance Portability and Accountability Act (HIPAA). It is important that you read the information carefully and please ask any questions you may have. We will give you a copy to take home.

FEES AND INSURANCE REIMBURSEMENT: While we are committed to providing high quality clinical services, the practice's primary purpose is to serve the community in a cost effective manner. Our practice contracts with AMBS, Inc. for billing services so expect to receive a statement from them about any coinsurance that may be due. You may bring any statement from AMBS, Inc. to the practice at your appointment and pay by credit card, check or cash.

MISSED APPOINTMENT POLICY: Missed sessions are problematic for both the clients and provider. Therefore, we ask clients to make a commitment to attend sessions regularly. If you find that regular attendance is a problem for you, we ask that you reconsider whether this is the most appropriate time or type of clinic for you. At times, you may do better to terminate therapy and start at a later date when you are able to make a regular commitment. The Clinic policy on missed appointments is as follows: If you must cancel a session, call the practice at (919)370-0946 and leave a message for your provider as soon as possible. Frequent cancellations or missed sessions may result in termination of therapy. If you wish to terminate therapy, we ask you to discuss this decision with your provider rather than simply failing to show up.

EMERGENCY AVAILABILITY: The Practice does not have 24-hour emergency coverage. In the event of an emergency, you may contact any of the following resources if you are in need of urgent care:

1. The local 24-hour crisis line can be reached by calling (919)913-4100. This is an anonymous phone counseling service staffed by trained volunteers; Otherwise, dial 911
2. The emergency room of the hospital nearest to you (Chatham Hospital: (919)799-4000) or call UNC Hospitals at (919)966-4131 and ask to speak to the psychiatrist or crisis worker on call.

HIPAA – THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: The Health Insurance Portability and Accountability Act (HIPAA) is a federal law whose health information privacy protections became effective on April 14, 2003. HIPAA provides additional privacy protections for medical records and establishes patient rights with regard to the use and disclosure of your Protected Health Information (PHI). PHI is your medical, billing and demographic information collected and created or received by the Practice for the purposes of treatment, payment, and health care operations. HIPAA requires that the clinic provide you with a Notice of Privacy Practices. Our Notice, which is attached to this document, explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that the Practice has provided you with this information at the end of this session. HIPAA permits use of PHI for teaching purposes.

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LIMITS ON CONFIDENTIALITY: Both North Carolina and federal law generally protect the privacy of communications between a patient and a provider. In most situations, the Practice cannot release information about your treatment to others unless you sign a specific written authorization or consent. However, there are certain situations in which the Practice is mandated or permitted to disclose confidential information without your consent or authorization. These situations are outlined in the attached University Notice of Privacy Practices. If such a situation arises, your provider will try to contact you before taking any action and will limit disclosure only to the information minimally necessary in the situation.

CONSENT AND ACKNOWLEDGEMENT: I understand I have the right to review the University’s Notice of Privacy Practices prior to signing this document. This Notice describes the types of uses and disclosures of my PHI that may occur in my treatment, payment of my bills or in the performance of health care operations of the Practice. The Notice also describes my rights and the Practice’s obligations with respect to my PHI. In addition to the copy I receive today, the Notice is also provided on the following website: https://nursing.unc.edu/files/2012/11/Notice-of-Privacy-Practices_Carolina-Nursing-Associates1.pdf The University reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by accessing the University’s website, calling the Practice office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I consent to the use and disclosure of my protected health information by the Practice for the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment, or conducting health care operations of the Practice. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document. I may revoke my consent in writing at any time. That revocation will be binding when received by the Practice unless a) the Practice has already taken action in reliance on my consent, b) the Practice has legal obligations imposed by a court of law or by my health insurer in order to process claims made under your policy, or c) I have not satisfied financial obligations I have incurred. My signature on this document is my consent for treatment, payment and health care operations and my acknowledgement that I have been informed about and received a copy of the University’s Notice of Privacy Practices.

Client Name: ___________________________________________
Client Signature: ___________________________ Date: _________________
Witness/Provider Signature: ___________________________ Date: _________________

I, as his/her guardian, give my consent to the procedures as described above.

Guardian Name: ___________________________________________
Guardian Signature: ___________________________ Date: _________________