Rowan University

ROWAN UNIVERSITY WELLNESS CENTER CONSENT FOR IN-PERSON AND TELEHEALTH TREATMENT

I hereby grant permission for the Rowan University Wellness Center staff and its medical providers (including physicians, nurse practitioners, physician assistants and mental health clinicians) to provide me with appropriate medical and mental health care evaluations, treatment and other medical services as necessary. I also give permission to the Rowan University Wellness Center to secure proper treatment for me, in case of medical or surgical emergency, if, according to their best professional judgment, further delay might jeopardize my welfare. I further authorize the Wellness Center to share my medical information with emergency room personnel.

I understand that in the event that I sustain a serious illness or injury, my parent(s) or legal guardian(s) may be notified at the discretion of the Wellness Center staff. In addition, I authorize the Wellness Center to contact me by telephone to check on my wellbeing if the staff is concerned about me, loses contact with me, or if I fail to attend a scheduled consultation. I further understand that if I am showing signs that I am unsafe, the Wellness Center requires that it has permission to reach out to an authorized emergency contact to ensure my safety such as: a personal contact (parent, guardian, spouse or partner); professional contact (a student affairs professional, a residence hall director, or a personal physician); or an office or agency that does crisis well-being checks in my community (typically, a 24-hour crisis service or the police department).

I understand that Wellness Center staff, including Student Health Services nursing and medical providers, Counseling and Psychological Services counselors and psychiatry providers, Alcohol and Other Drug Services providers and Pet Therapy Services shall all have access to my medical and mental health information, with the exception of psychotherapy notes, as it relates to health care services rendered to me at the Wellness Center, and I understand that any/all of these providers may disclose my health information to people outside of the Wellness Center who provide services that are part of my care.

I also understand that there are exceptions to confidentiality wherein Wellness Center staff may be required to disclose information from my medical record; for example, mandatory reporting of child abuse, suicidality, credible threats of violence, or court order. In such case, confidential information will be shared with appropriate parties (e.g., emergency room staff, an identified potential victim, the NJ Department of Children and Families, etc.) to ensure safety, well-being, or as otherwise required by law.

I may opt to schedule a telehealth appointment. Telehealth allows my medical provider and/or mental health provider to diagnose, consult and treat using electronic communication (such as telephone, video, internet, smartphone, laptop, tablet, PC desktop system or other electronic means). By agreeing to a scheduled telehealth visit, I hereby consent to participating in treatment and/or psychotherapy via electronic communication. I understand that the same confidentiality standards that apply to a medical or mental health in-person visit also apply to a telehealth visit. I also understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

I further understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that our therapy sessions could be disrupted or distorted by technical failures. My provider may, at any time, determine that due to certain circumstances, telehealth is no longer appropriate, and recommend the resumption of in-person sessions. If I choose to use telehealth, I understand that I am responsible for finding a private and quiet location where the consult can occur uninterrupted. I further understand that I have the responsibility for maintaining the confidentiality of my WIFI connectivity link and the security of my electronic device (tablet, laptop, phone or computer).

I understand that I have the right to receive medical or mental health services from the Wellness Center regardless of my insurance provider. If I have purchased the student health insurance plan, I understand that the plan will be billed for most services received at the Wellness Center and my medical claim information will be available through the online Aetna Navigator. I understand that medical chart audits may be performed to improve healthcare operations, support medical claims, review utilization data and conduct quality assurance measures, either internally or by business associates that have entered an agreement to protect the confidentiality of my protected health information.

I have been advised that the Wellness Center's Privacy Practices for Protected Health Information contains additional information regarding my patient rights, and that the Wellness Center's Telehealth Consultation and Treatment Information Form contains information about the risks and benefits of telehealth, and that I can obtain a copy of both documents from the Wellness Center waiting room, the Wellness Center website, or when I initially check in at the start of treatment.

I understand that the Wellness Center may use my contact information to text/email me with appointment reminders and/or satisfaction survey requests. I understand that certain services utilize email, text, videoconferencing and online support which may not be secure, and that the Wellness Center has incorporated network and software security protocols into their electronic systems to protect the confidentiality of my protected health information, including imaging data. I further understand that a variety of alternative methods of medical care and counseling services may be available to me, and that I may choose one or more of these at any time. My provider (physician, nurse practitioner, physician assistant or mental health clinician) has explained the alternatives to my satisfaction.

My encounter will be documented in my Rowan University electronic health record in accordance with HIPAA guidelines. I understand that I have the right to inspect all information obtained and documented in my electronic health record in the course of any service, and may, upon request, receive copies of this information.

I understand that if I fail to cancel any appointment prior to my scheduled appointment time, a $10.00 fee will be charged. I further understand that if I am not checked in or able to connect via electronic device(s) within 10 minutes of a scheduled appointment time, the Wellness Center may need to reschedule the appointment.

I have been advised that there will be no recording (video or audio) of any appointments during any encounter at the Wellness Center by any staff member, unless I provide my specific consent.

This authorization will remain in effect as long as I am a student at Rowan University and replaces any previous authorization(s).

I certify that I have carefully read and understand this Consent for In-Person and Telehealth Treatment before signing it. I further acknowledge and agree that a typed signature, facsimile copy, PDF, or photocopy of my signature hereto shall be valid and shall have the full force and effect as an original.

_____ _____

PRINT STUDENT NAME STUDENT ID#

_____ _____

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE DATE

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IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO CLIENT