Governing Law and Jurisdiction Agreement

for healthcare organizations

This agreement ("Agreement") is entered into by and between _____ and
[Name of patient]

Queen's Student Wellness Services (collectively, the "Parties").
[Healthcare organization]

Governing Law

The Parties hereby agree that:

a) all aspects of the relationship between _____ and
[Name of patient]

Queen's Student Wellness Services (as well as her/his agents, delegates, employees, and any
[Healthcare organization]

physicians and other independent healthcare practitioners providing medical or other healthcare and treatment to _____, or in association with Queen's Student Wellness Services),
[Name of patient] *[Healthcare organization]*

including without limitation any medical or other healthcare and treatment provided to _____, and
[Name of patient]

b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement,

shall be governed by and construed in accordance with the laws of the province or territory of Ontario
[Province or territory]

(other than conflict of laws rules) and the laws of Canada applicable therein.

Exclusive Jurisdiction

The Parties hereby acknowledge that the medical or other healthcare and treatment received by _____ from Queen's Student Wellness Services will be provided in the
[Name of patient] *[Healthcare organization]*

province or territory of Ontario, and that the Courts of Ontario
[Province or territory] *[Province or territory]*

shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other healthcare and treatment, or from any other aspect of the relationship between _____ and Queen's Student Wellness Services.
[Name of patient] *[Healthcare organization]*

Date: _____

_____
Name of patient *[Please print]*

_____
Signature of patient / substitute decision-maker on behalf of patient

Date: _____

Per: Queen's Student Wellness Services
[Healthcare organization]

_____
Name *[Please print)]*

Student Wellness Services
Demographic Information

Personal Information

Student #:_____ **Date of Birth (YY/MM/DD):**_____

First Name: _____ **Last Name:** _____

Phone Number: _____ **Can we leave a voicemail?** ☐ Yes ☐ No

Preferred name (optional)**:**_____ **Preferred Pronoun** (optional):_____

Sex assigned at birth: M ☐ F ☐ Intersex ☐ **Gender** (optional) _____

Health Card Number: _____ **Province** (health card): _____

Kingston Address:

_____

Street Name & Number Apartment City Province Postal Code

Permanent / Family Address: ☐ **(If same as above)**

_____

Street Name & Number Apartment City Province Postal Code

Emergency Contact Information

We collect this information in the unlikely event that we would need to notify someone of a potentially life-threatening situation, a situation in which you are unable to direct your own care, or a situation where you can not be found. Please note that your SWS Emergency Contact information is separate from other Emergency Contact information you provide to the university and will not be shared with other divisions or services within the university. As such, please ensure that your emergency contact information is updated on your Solus account.

EMERGENCY CONTACTS (preferably family or someone who you know well:

First Emergency Contact (Required)

Name: _____ **Relationship:** _____

Phone 1 #: _____ **Phone 2 #:** _____

_____

Street Name & Number City Prov/State Country Postal Code

Second Emergency Contact (Optional)

Name: _____ **Relationship:** _____

Phone 1 #: _____ **Phone 2 #:** _____

_____

Street Name & Number City Prov/State Country Postal Code

Please Complete Reverse

Student Wellness Services
CONFIDENTIAL INTAKE INFORMATION

Academic Information

Faculty/School: _____Program:_____ Year of Study:_____

1. ☐ Undergraduate Student ☐ Graduate Student ☐ Professional Student
2. ☐ Full-time Student ☐ Part-time Student ☐ Interest Student
3. ☐ Domestic Student ☐ International Student ☐ Exchange Student

No Show Policy

We ask for 24 hours notice when cancelling an appointment. If you miss your appointment without cancelling, fees will apply at the following rates

SERVICE	FEE
Counselling session with a COUNSELLOR/MENTAL HEALTH NURSE	$30.00
10 minute PHYSICIAN appointment	$30.00
20 or 30minute PHYSICIAN appointment	$60.00
60 minute PHYSICIAN/PSYCHOTHERAPY appointment	$120.00
20-30 minute PSYCHIATRY appointment	$60.00
31-60 minute PSYCHIATRY appointment	$120.00
61-90 minute PSYCHIATRY appointment	$180.00
10 minute NURSING appointment	$10.00

Charges are to be paid at reception within 30 days. If payment is not received in 30 days the charges will be applied directly to your Queen's SOLUS account.

THIRD PARTY/UNINSURED SERVICES

Not all medical services are covered by OHIP. These include insurance & other form completion, driver medicals, third party medicals, travel consultations/vaccinations, appeals, etc. Many are covered by your employer's health insurance plan or other 3rd party insurance plans. Patients will be advised of such charges and payment methods. All charges for uninsured services must be settled at the point of services

SIGNATURE: _____ **DATE:** _____

This information will be used to maintain client records. All privacy regulations as per PHIPA will be abided by.

PLEASE NOTE: Student Wellness Services provides care to students currently enrolled at Queen's University. In other situations, please discuss with the Clinic Manager.

If you would be interested in participating in focus groups, interviews, or other similar activites to provide feedback / input on SWS programs and services, please check the box ☐ Yes, please contact me by email if there are opportunities to participate

STUDENT WELLNESS SERVICES (SWS)
STUDENT EMAIL CONSENT FORM

Please complete all areas that are starred (*)

* **Student's Name:** _____

* **Student's Date of Birth:** _____

* **Student Number**:_____

* **Queen's Email**: _____

1. EMAIL COMMUNICATION

Student Wellness Services uses email to communicate information that may be of a sensitive nature to students. This includes information about appointment bookings, rescheduling appointments, invoices, referral updates, test result follow-ups, and other similar information.

2. RISK OF USING EMAIL

Risks to consider include but are not limited to:

a) Email can be circulated, forwarded, stored, printed, and broadcast to unintended recipients.

b) Email senders can misaddress an email.

c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.

d) Queen's University has the right to inspect email transmitted through their systems.

e) Email can be intercepted, altered, forwarded, or used without authorization or detection.

f) Email can be used to introduce viruses

3. CONDITIONS FOR THE USE OF EMAIL

SWS cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. The Student and SWS must consent to the following conditions:

a) Email is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular email will be read or responded to.

b) Email must be concise. The Student should schedule an appointment to discuss the details of an issue.

c) Email communications will be filed in the Student's permanent health record or departmental file.

d) Emails may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.

e) Emails sent by students will not be forwarded outside of SWS without the Student's prior written consent, except as authorized or required by law.

f) Email shoud not be used for communication regarding details of medical or health conditions.

g) It is the Student's responsibility to follow up and /or schedule an appointment if warranted.

h) Medical / health advice will not be provided by email

i) SWS is not responsible for technical failures which may preclude receipt of your emails.

4. AUTOMATED EMAILS

SWS sends automated emails to remind students of appointments. The automated reminders contain information about the date and time of the student's appointment at SWS. SWS may also send emails with a link to provide feedback on SWS services. These automated emails do not contain any information about the appointment or nature of service received.

5. STUDENT ACKNOWLEDGMENT AND AGREEMENT

- I understand the risks associated with the communication of email between SWS and me.
- I understand that if I initiate contact by email, SWS may take that as consent to reply by email to the content of my email.
- I understand that I can choose to consent to email as a means of contact for SWS.
- I understand the conditions and instructions outlined here, and accept that SWS may impose other instructions related to communicating with me by email.
- I agree to use only the pre-designated email address specified above.
- I understand that in using Student Wellness Services, I acknowledge that I have read, understand and accept the practices described above.

* _____(Initials) I give consent for SWS to use email as a means of contact with me.

* _____(Initials) I **do not** give consent for SWS to use email as a means of contact with me. I understand this means I will not receive appointment reminders.

* **Student Signature** _____

* **Date**

_____

* **Witness Signature**_____

* **Date**_____

Revised 05/18

Claim authorization form

Sun Life Financial

Member information

Name of University/College/School Board		Policy number	Member ID
Member's last name	Member's first name		
Member's telephone number	Member's email address		
Canadian address (street number and name)		Apartment or suite	
City		Province	Postal code
Healthcare provider or name of clinic			

Spouse and/or dependents covered by the member's coverage

First name	Last name

Authorization and signature

I authorize the healthcare provider/clinic named above to submit claims on my behalf to Sun Life Assurance Company of Canada (Sun Life).

I agree that Sun Life can make payments directly to the Provider. I understand that payment by Sun Life to the Provider discharges Sun Life's payment obligation to pay me. Sun Life may pay me directly for claims despite this signed Claim Authorization Form and that any payment to me instead of the Provider discharges Sun Life's payment obligation.

I authorize Sun Life, its agents and services providers and as applicable the plan administrators to collect, use and exchange information needed for underwriting, administration, adjudicating claims and claims management under this insurance coverage. This information can be shared with any person or organization who has relevant information about me including health professionals, government agencies, provincial health care plan, institutions, investigative agencies insurers, reinsurers and, as applicable, the plan sponsor and plan administrator. I understand that for audits and administrative reporting, the plan sponsor or administrator of this insurance coverage may have access to statistical and financial information without person identifiers.

If there is suspicion of fraud and/or abuse related to my claim, I understand and agree that Sun Life, its agents and service providers may exchange information about my claim for the purpose of investigation and prevention of fraud and/or abuse with any relevant organization, including as applicable the plan sponsor and plan administrator, law enforcement bodies, regulatory bodies, government organizations and other insurers.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me.

If I am submitting claims for my spouse and/or dependents, I confirm that I am authorized by them to disclose personal information about them for the purposes described above to Sun Life, its agents and services providers and any person or organization who has relevant information about them including health professionals, government agencies, provincial health care plan, institutions, investigative agencies insurers, reinsurers and, as applicable, the plan sponsor and plan administrator.

I agree that a photocopy or electronic version of this authorization is as valid as the original. This authorization shall continue to have effect until revoked by me. I understand that this form will be kept on file by the Healthcare Provider or Clinic.

Member signature	Date (dd-mm-yyyy)
X	

STATEMENT OF PRIVACY AND CONFIDENTIALITY RE PERSONAL HEALTH INFORMATION

Student Wellness Services (SWS) is committed to protecting your privacy and the confidential nature of the information you share. This statement outlines the personal health information practices we use to protect your privacy, and your rights under Ontario law, known as PHIPA (*Personal Health Information Protection Act, 2004*). This statement applies to individuals accessing physical and mental health care services from a doctor, nurse, occupational therapist, personal counsellor, social worker, psychologist, psychotherapist, or psychiatrist at Student Wellness Services. **Please review and sign.**

Collection and Use of your Information

To provide you with quality health care, we keep an electronic record of information about your health status and of the care that we have provided to you. The team of health care providers at Student Wellness Services uses an integrated electronic health record to document the provision of care. Personal health information is collected, used, and disclosed by Student Wellness Services as permitted or required by law. Your personal health information is only to be accessed by a SWS health care provider or staff member as part of fulfilling their job duties and providing or assisting in the provision of health care.

Consent to Use and Share your Information to Provide You with Health Care

In almost all cases, your consent is required to collect, use, and disclose your personal health information. Consent means you are knowledgeable and informed about the collection, use and disclosure of your personal health information. Consent can be implied (assumed) or explicit (verbal or written).

Implied Consent

- When you seek health care from us, we assume that we have your permission to collect, use and share your personal health information among the health care providers and administrative staff at Student Wellness Services who provide or assist in providing health care to you. The sharing of personal health information among the Student Wellness Services team streamlines and enhances the care provided to you (e.g. a doctor may ask a nurse to call you with lab results; a counsellor may consult a manager etc.)
- We also rely on implied consent to share your personal health information on a 'need-to-know' basis with other health care providers outside of Student Wellness Services who are directly involved in your health care (e.g. fax a prescription to your pharmacist, or send a referral to a specialist).
- We also rely on implied consent to share personal health information with health insurance providers (e.g. OHIP) for billing-related purposes.

Express Consent

In most cases, your verbal or written consent is required to disclose personal health information from or with anyone who is not directly involved in providing or assisting in providing health care services to you (e.g. a family member). See below - "Campus Community".

Limits to Confidentiality and Requirement of Consent to Receive or Disclose Information
We must also meet legal requirements to disclose personal health information in specific circumstances without your consent (i.e. situations where you are thought to be at risk of harm to yourself or others; a request from a legal authority; in cases of suspected child abuse, elder abuse in a long-term care facility, and sexual abuse by a Regulated Health Care Professional; in cases when a medical condition significantly impairs your ability to operate a motor vehicle).

Withdrawing or Restricting Consent ("Lockbox") to Access to Personal Health Information
You have the right to withdraw or restrict partial or complete access (other than to those with legal authority under PHIPA) to the personal health information within our health record. If you have concerns related to your privacy or the confidentiality of your information, please speak to your health care provider and we will work with you to address those concerns. Written instructions from you (lockbox form) are required to restrict access to your file. Requesting a lockbox may result in implications for your health care, and possible risks will be reviewed with you individually should you request a lockbox from Student Wellness Services.

Security and Protection of your Information
We will take reasonable steps to keep accurate records of your health information and will follow all legal requirements and Queen's security standards and best practice for the security, retention and destruction of these records. All medical records are kept for a period of time determined by the medical licensing authority or other professional oversight body.

All healthcare professionals and administrative staff at SWS work under PHIPA and adhere to the privacy and security policies of Student Wellness Services. If you become aware of any inappropriate use of your personal health information or a breach of confidentiality, please inform us immediately. Under PHIPA, you may also file a written complaint to Ontario's Information and Privacy Commissioner.

Access to your Health Record
Unless there are unusual circumstances, you have the right to review and/or obtain copies of your health record. If access or copies are provided, our clinic may charge a reasonable fee to cover our expenses.

Changes to your Health Record

You can request a change to the information in your health record if you think that there is an error or an omission in the record. The health care practitioner will consider your request and either grant or refuse it based on their review. We will place a notation on your health record that you requested the amendment, along with the details of the decision made.

Third Party Consent
If there are individuals in your life whom you wish to have involved in your health care while at Queen's, we will ask you to sign a SWS *Consent regarding Personal Health Information* form for each person. Please note you can choose what type of personal health information you want us to receive or disclose and you can withdraw consent at any time.

Campus Community

Student Wellness Services may be contacted by an individual (e.g. parent/family member, housemate, friend, faculty or staff member, residence life, Student Affairs, campus security, chaplain) who is concerned about your well-being. We will collect information from these individuals and may reach out to you, as appropriate, to follow-up on the concerns that have been brought to our attention, and to connect you to supports if needed. We inform the concerned individual that we may reach out to you, but no additional information will be provided. **Please note we do not disclose any personal health information about you or your use of our services at any time, unless there is believed to be an imminent risk to your safety or the safety of someone else.** If you have any questions about personal health information privacy and confidentiality, you may contact the Clinic Manager or the university's Chief Privacy Officer.

Acknowledgement and Acceptance

I acknowledge that I have had the opportunity to review the above **Statement of Privacy and Confidentiality** about my personal health information. In using Student Wellness Services, I acknowledge that I have read, understand and accept the practices described above.

Student Name (please print): _____

Student Number: _____

Student Signature: _____

Date: _____

Last update: January 2020