Student Consent – Usage of Student Wellness Services

STUDENT WELLNESS SERVICES
Mitchell Hall
69 Union Street
Queen's University
wellness.services@queensu.ca

Name:

Student #:

Date of Birth:

Provincial Health Card/Private insurance #:

Province of Health Card:

Preferred Name:

Kingston Address:

Phone #: Queen's email address:

PRIVACY AND CONFIDENTIALITY

Patient consent to the collection, use and disclosure of Personal Health Information

Queen's Student Wellness Services (SWS) including medical services and mental health services, utilize the Electronic Medical Record Oscar and Ventus (QSAS) to document your visits and communications in order to facilitate your care.

Queen's complies with the *Personal Health Information Protection Act*, *2004*, and only collects information that is necessary for your care. We:

- keep accurate and up to date records
- safeguard the medical records in our possession
- share information with other health care providers only when required for your health care
- disclose information to third parties only with your signed consent or when legally required
- conduct patient satisfaction surveys
- compile statistics for such reasons as improving practice or supporting budgets, etc.
- retain and destroy records in accordance with the authorized records retention schedules.

Your request for care from SWS implies consent to collect, use and disclose personal health information as set out by the University privacy policy (https://www.queensu.ca/secretariat/policies/administration-and-operations/policy-handling-personal-health-information) unless a particular collection, use or disclosure is permitted or required by law without consent including but not limited to situations such as child abuse, issues concerning driving, flying etc. If you have concerns about your privacy, you can talk to your health care practitioner at any time to discuss those concerns. You have the right to access your records, request a change or request a third party receive information from your chart. You have the right to withdraw or restrict consent (lockbox) for access to your personal health information within your record. A lockbox form is required to restrict access to your file and is obtained by speaking with one of the reception team members. Requesting a lockbox may result in implications for your health care, and possible risks will be reviewed with you individually should you make this request.

☐ I understand and agree to the above statement

EMAIL COMMUNICATION

SWS uses Queen's University email to communicate with patients with regard to appointment reminders, referral notifications and notifications to call or videoconference the clinic. Email is not a secure form of communication and comes with some risk. You have the right to decline email communication and revoke inclusion of your email address in your confidential health record. If you

chose to not include your email on your record or want to revoke your email, please speak to a receptionist. If you have not notified reception that you wish to decline email communication or revoke prior authorization for email communication, you are authorizing the ongoing use of such communication when you submit this form.

☐ I understand and agree to the above statement

GOVERNING LAW AND JURISDICTION FOR LEGAL ACTION

I hereby agree that the relationship and the resolution of any and all disputes arising therefrom between myself and any member, past or present, of the staff of Queen's Student Wellness Services shall be governed by and construed in accordance with the laws of the Province of Ontario, and shall be adjudicated in Ontario.

☐ I understand and agree to the above statement

NO SHOW AND CANCELLATION POLICY

Student Wellness Services requires 24 hour prior notice of cancellation of an appointment (a message can be left on the cancellation line at 613-533-2506, 24 hours per day). In the case of appointments scheduled the same day or within 24 hours, please provide notice of cancellation as soon as possible. Failure to arrive on time, keep an appointment or to provide adequate notice will result in a fee being charged based on the schedule below. Charges are to be paid at the clinic within 30 days. If payment is not received in 30 days the charges will be applied directly to your Queen's SOLUS account.

10 minute = $35 per physician appointment……$35.00

20 minute physician……..$70.00

30 minute physician appointment……..$105.00

40 minute physician appointment……$140.00

120 minute GP Psychotherapy appointment……$210.00

Third Party/uninsured services

Not all medical services are covered by OHIP or other provincial insurance. These include insurance and other form completion, drive medicals, third party medicals, travel consultations/vaccinations, appeals etc. Patients will be advised of such charges and payment methods. All charges for uninsured services must be settled at the point of services.

☐ I understand and agree to the above statement

WHEN YOU LEAVE THE UNIVERSITY

Student Wellness Services provides care to students currently enrolled at Queen's University, or in certain circumstances students visiting from other schools. Upon graduation or withdrawal from the University, you may continue to use Student Wellness Services for a maximum of 3 months. During this time, you should be actively looking for a new provider. Once you have a new physician, we can forward your medical records to your new provider with your written authorization to assist in the continuity of care.

I have read, understand and consent to the above terms and acknowledge that should I wish to receive a copy of this consent, I can request it at the reception desk. By marking each of the above checkboxes, I understand this represents my digital signature of agreement.

☐ **I accept these terms**

_____

Name

_____

Signature

_____

Date

PROVIDER RELEASE FORM AND ASSIGNMENT OF BENEFITS

SECTION 1 – Member Information

Member Name (*Last Name, First Name*):	Certificate Number:

SECTION 2 – Patient Information

Patient Name:	Date of Birth (*dd/mm/yyyy*):

SECTION 3 – Provider Section

Attention Provider - please attach an itemized INVOICE(s) to this form. ****Physicians and Hospitals* **must provide or include the diagnosis.

SECTION 4 – Member Authorization (*To be completed by member*)

I agree that I am responsible for all claims submitted under my plan and have reviewed the claim and information that is being submitted by this provider. **I certify** that my spouse and / or my dependants of minor or major age ("Dependants") have received all goods and services claimed and that the information provided is true and complete. **I authorize** Cowan Insurance Group to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purpose of group benefits plan administration, audit and the assessment, investigation and management of this online claim ("Purposes"). I am authorized by my dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of the benefits program to collect, use, maintain and exchange this Information with each other and with Cowan Insurance Group, and or its service providers, for the Purposes. **I agree** that both monies and overpayments that I may owe to Cowan Insurance Group in accordance with the provisions of the group benefits plan with Cowan Insurance Group, and **I authorize** Cowan Insurance Group to deduct such monies from my future claims. **I understand** Cowan Insurance Group reserves the right to classify my claim submission as an overpayment, revoke online claiming privileges, and/or notify my plan sponsor should I provide false, incomplete or misleading information. **I understand** Cowan Insurance Group reserves the right to verify with my service provider the accuracy of all claims information submitted online. **I authorize** the use of my group benefit plan certificate number for the purpose of identification and administration. **I agree** a photocopy facsimile or electronic version of this authorization shall be as valid as the original. **I understand** that Cowan Insurance Group's privacy policy is available at http://www.cowangroup.ca/privacy-policy.

Date: _____ **Member signature:** _____

If the payment should be made to the provider:

I hereby assign my benefits payable from this claim to the provider and authorize payment directly to him/her.

Date: _____ **Member signature:** _____

Cowan Insurance Ltd.
700-1420 Blair Towers Place
Ottawa, Ontario K1J 9L8
Phone: 1 (888) 509-7797 or 1 (613) 741-3133
Fax: (613) 741-7771
Email: providers@cowangroup.ca