Student Consent – Usage of Student Wellness Services

Name:

Student #:

Date of Birth:

Provincial Health Card/Uhip/Private insurance #:

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

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 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.

20 or 30 minute 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

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

Email Form

_____

Date

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	