

**IUPUI CAMPUS HEALTH GENERAL CONSENT FORM, GUARANTEE OF PAYMENT  
AND ACKNOWLEDGEMENT OF NOTICE**

**Treatment:** I authorize IUPUI Campus Health (IUPUI CH), its agents and employee to furnish medical care and services, including but not limited to, diagnostic tests, examinations, digital photos for treatment and documentation, and other medical and/or surgical procedures, which are deemed necessary in the course of my care. I agree that IUPUI CH cannot make any explicit guarantee or promises regarding results or cures.

**Teaching Environment:** I understand that IUPUI CH is part of a teaching environment and at times I may be asked to allow students, residents and fellows to be involved in my care and that my medical records, including digital photos, may be used for purposes of research and education, so long as all personal identifiers are removed.

**HIPAA Privacy Practice:** I acknowledge that IUPUI CH has given me or offered a copy of their Notice of Privacy Practice and I understand that I may request a copy of this notice should I so choose.

**Infectious Disease Testing:** I agree to allow IUPUI CH to test for infectious diseases including hepatitis and human immunodeficiency virus (HIV) if one of my caregivers is exposed to my blood or body fluid. In reciprocity, if I am exposed to any blood or body fluid during my treatment, I can request the source person be tested for such infectious diseases in accordance with Universal Protocol; at no cost to parties being tested. All parties invoiced will have access to results

**Financial Agreement:** In consideration for providing medical care and services, I understand that I am financially responsible for all fees and charges. CH will provide information regarding fees for services upon request.

**Payment Responsibility:** I am responsible for paying for all the care I receive, and if insurance does not cover all the cost, I must pay the remaining balance. I agree IUPUI CH may release my medical records as necessary to receive all payments that I am entitled to under insurance policies. I am responsible for knowing what insurance coverage I have and for following insurance policy rules.

**Bursar Account (if active):** I authorize IUPUI CH to place my health service charges onto my Bursar account. By initialing, I understand that I am entering into and agreeing to a legally binding contract to pay all fees assessed to my bursar account. I understand that if I allow my bursar account to become delinquent, University services, such as future registration, transcripts, diploma and other certification will be encumbered until such time as my account is paid in full. In addition, I understand that IU may refer my past due account for collection, report my delinquency to the credit bureau system and may authorize legal action against me for the collection of this debt. I agree to be liable for all reasonable collection costs, including attorney fees, collection agency fees and court costs necessary for the collection of any past due amount. I understand and agree that if I leave any IU campus with an unpaid balance, that I authorize the University and/or its agents, including attorneys and collection agencies to contact me via cellular telephone and/or all forms of electronic technology (including text messaging/email) to collect such outstanding debt, unless I notify the agent in writing to cease electronic/cellular communication.

**Referrals:** Your provider may refer you to an out of network provider for health care items or services. An out of network provider is not bound by payment provisions that apply to health care items or services rendered by a network provider under your health plan. You may contact your health plan before receiving health care items or services rendered by an out of network provider to obtain a list of network providers that may render the health care items or services and for additional assistance.

**Duration of Consent:** This consent will be valid for one (1) year from the date of signature below. I may revoke my consent for release of this information at any time, except to the extent that action has been taken in reliance on the consent.

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Communication Authorization:

I authorize IUPUI Campus Health to contact me by:

Text message at \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ If you want to use texting, we require your authorization to do so.

Email \_\_\_\_\_@iupui.edu @iu.edu or @indiana.edu (Please circle your email domain). An email message is sent to you after you are web-enabled.

I understand I have the right to revoke this communication authorization part of this consent at any time. You must do so in writing and deliver the document to IUPUI CH. Alternatively, complete the Revoke Communication Authorize form and return to the IUPUI CH.

IUPUI CH can contact you by telephone but need your written permission to use other types of communication. CH requests your permission to contact you by text or email with information regarding your health care. CH has enabled a portal for your use to securely perform the following: view lab results, vaccination information, make appointments, and communicate via email. An email is sent to you upon activation of the portal. Email sent through the University's email system is secure, but the portal has additional security measures.

Security of email sent from outside the University system or by text messages are not secure and there is a risk that the messages could be intercepted and read by someone other than yourself. Therefore, we request to use your University email address. IUPUI CH will not send you emails outside the University system.

I have read the above and have had the opportunity to ask questions. I understand my rights and obligation as described in this consent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date