Student Health Services
UNIVERSITY OF SOUTH CAROLINA

TREATMENT AGREEMENT & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Information

Patient Name:_____ Date of Birth:_____

USC ID:_____

CONSENT FOR TREATMENT/ CARE:

I am the above named patient or patient's legal representative and hereby give permission for Student Health Services (SHS) and its physicians, healthcare providers, healthcare clinicians, staff and outside companies to perform routine medical or mental health treatment. Including but not limited to blood draws, medications, examinations, treatments, lab tests therapy, treatment services and procedures as may be advised and necessary in accordance with the judgement of the medical and mental health team of providers and clinicians. I acknowledge that no guarantee can be made concerning the results of treatments. Diagnostic and laboratory procedures that may be ordered for me include but are not limited to testing for diseases such as COVID-19, Sexually Transmitted Diseases and Methicillin-Resistant Staphylococcus Aureus (MURSA). I have the right to understand and participate in assessment and treatment and the right to ask questions in order to understand options and consequences of different choices.

ACKNOWLEDGEMENT:

I attest that SHS has provided me with a copy of its Notice of Privacy Practices to review. The Notice describes how medical and mental health information about me may be used and disclosed and how I can gain access to this information. I understand that it is the responsibility of this office to provide me with its Notice of Privacy Practices on the first services encounter. If my first date of service with this office was due to an emergency, I understand that it is the office's responsibility to provide me with this Notice and obtain my signature as acknowledgement of receipt as soon as possible following the emergency.

By signing this form, I acknowledge that I have read, understood, and consent to treatment and care and I acknowledge the receipt of the Notice of Privacy Practice.

_____	_____	_____
Patient/Legal Representative Signature	If signor is not the patient, state relationship	Date

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SHS INTERNAL STAFF USE ONLY

COMPLETE IF ACKNOWLEDGEMENT FORM IS NOT SIGNED:

1. Was the patient given a copy of the Notice of Privacy Practices?
   - ☐ **Yes**
   - ☐ **No**
2. If the form is not signed, explain why and your efforts to obtain the patient's signature:

_____

_____

_____	_____	_____
Staff Signature	Print Your Name & Title	Date