WELLESLEY COLLEGE

HEALTH SERVICE

CONSENT FOR CARE AND TREATMENT

PERMISSION FOR TREATMENT

I understand that the information that I have given in the pre-entrance health history is confidential and is only for the use of the Wellesley College Health Services and Stone Center Counseling Services (the "Wellesley College Treatment Providers"). I hereby authorize Wellesley College Health Service to provide diagnostic and therapeutic treatment to me, including voluntary immunization, as deemed necessary by the medical staff.

STUDENT'S SIGNATURE DATE

STUDENT'S PRINTED NAME DOB: (MM/DD/YY) DATE

PERMISSION TO DISCLOSE HEALTH INFORMATION

I understand that there may be times, in connection with my treatment, when the Wellesley College Treatment Providers will need to disclose my health information to healthcare providers who are external to Wellesley College ("Non-Wellesley providers") and, as part of a treatment team, are providing treatment to me. I also understand that Non-Wellesley providers may need to disclose my health information to the Wellesley College Treatment Providers, if the Non-Wellesley provider believes it is needed for the purpose of treating me**.** I authorize the Wellesley College Treatment Providers to share my health information with Non-Wellesley providers if they believe that it is needed in connection with my treatment. I also authorize Non-Wellesley providers to share my health information with the Wellesley College Treatment Providers if they believe it is needed for the purpose of my treatment. I further understand that Wellesley College will disclose my health information only as otherwise required or permitted under state or federal laws.

STUDENT'S SIGNATURE DATE

STUDENT'S PRINTED NAME DOB: (MM/DD/YY) DATE

106 Central Street, Wellesley, MA 02481 Tel 781.283.2810 Fax 781.283.3693
Summer business hours Mon-Fri 10am-2pm

WELLESLEY COLLEGE
HEALTH SERVICE
CONSENT FOR CARE AND TREATMENT

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The Wellesley College Health Service does not charge students for office visits, but may charge for lab tests, immunizations, allergy injections, and procedures conducted during or in connection with an office visit. I understand that if I am enrolled in the Student Health Insurance Plan, the Health Service will submit claims for charges to the Student Health Insurance Plan and these charges are covered in full. However, should I waive the Student Health Insurance Plan, the Health Service will not bill my current insurance coverage provider for services rendered. I acknowledge that if I waive or have waived the Student Health Insurance Plan, I will be solely responsible for payment of any charges incurred at Wellesley College Health Service, and that I may seek reimbursement for services rendered at the Health Service from my current insurance coverage provider.

STUDENT'S SIGNATURE DATE

STUDENT'S PRINTED NAME DOB: (MM/DD/YY) DATE

CONSENT FOR TREATMENT OF MINORS (FOR STUDENTS UNDER 18 YEARS)

This consent form must be signed by the parent or legal guardian of minors (persons under 18 years) so that appropriate diagnostic and therapeutic treatment may be promptly carried out. *Please note: In emergency situations, every effort will be made to contact the parent/guardian, prior to treatment.*

The signature below acknowledges understanding and authorization of, and agreement with, the above statements regarding treatment, disclosure of health information, and acknowledgement of financial responsibility on behalf of the minor.

STUDENT'S NAME DOB: (MM/DD/YY) DATE

PARENT/GUARDIAN SIGNATURE DATE

PARENT/GUARDIAN'S PRINTED NAME DATE

106 Central Street, Wellesley, MA 02481 Tel 781.283.2810 Fax 781.283.3693
Summer business hours Mon-Fri 10am-2pm