

**USF Student Health Services
Triage Assessment**

Date: _____ **Time:** _____

Name: _____

Student I.D. # U-_____

Birth date: _____

Have you visited SHS within the past 2 years?

Yes No

If Yes, was it only for immunization compliance?

Yes No

Do you need a form completed for entrance into a University program?

Yes No

Briefly explain the reason for your visit today. Use the **back** of this sheet to list more specific details and symptoms.

When did the problem start? _____

Have you been evaluated for this issue at SHS within the past 2 weeks? Yes No

University of South Florida
Student Health Services
 4202 East Fowler Avenue, SHS100
 Tampa Florida 33620-6750
 Phone: (813) 974-2331
 Fax: (813) 974-7181

MEDICAL HISTORY

THIS INFORMATION WILL BE USED AS BACKGROUND FOR PROVIDING HEALTH CARE AND WILL BECOME PART OF YOUR CONFIDENTIAL MEDICAL RECORD. THIS INFORMATION WILL NOT BE RELEASED WITHOUT YOUR CONSENT. PER THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974 AS AMENDED.

PLEASE COMPLETE ALL SECTIONS LEGIBLY IN INK ONLY.

NAME: _____ DATE: _____
 _____ LAST _____ FIRST _____ MI _____
 STUDENT I.D. # _____ BIRTH DATE: _____ SEX: M F RACE: _____
 _____ (OPTIONAL)
 LOCAL ADDRESS: _____ LOCAL PHONE #: _____
 _____ STREET _____
 _____ PERMANENT PHONE #: _____
 _____ CITY _____ STATE _____ ZIP _____
 PERMANENT ADDRESS: _____
 _____ STREET _____ CITY _____ STATE _____ ZIP _____

	YOURSELF		FAMILY		RELATIONSHIP	ALLERGY	
	YES	NO	YES	NO		YES	NO
TUBERCULOSIS							PENICILLIN
DIABETES							SULFA DRUGS
KIDNEY DISEASE							TETRACYCLINE
HEART DISEASE/HIGH BLOOD PRESSURE							OTHER DRUGS (SPECIFY):
ARTHRITIS							
STOMACH DISEASE							
ASTHMA							SERUM
EPILEPSY, CONVULSIONS							FOODS(WHICH):
HEPATITIS, LIVER DISEASE							
CANCER							
PSYCHIATRIC ILLNESS							Environmental Allergies (specify)
THYROID DISEASE							
DISABILITY OR SPECIAL PROBLEM							
OTHER (SPECIFY)							
SHS USE ONLY:					Are you receiving allergy injections:	CURRENT MEDICATIONS: (including birth control pills)	
					Yes ___ No ___		

HOSPITALIZATIONS: _____ SURGERY: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:(Parent, Guardian, Spouse, Other)-RELATIONSHIP _____

NAME: _____ ADDRESS: _____

PHONE #: _____
 _____ (AREA CODE) _____ CITY _____ STATE _____ ZIP _____

PERMISSION FOR DIAGNOSTIC & TREATMENT PROCEDURES:

I hereby authorize the health care providers of the Student Health Services, their agents or consultants, to perform diagnostic and treatment procedures that in their judgment may become necessary while at the University of South Florida. In the event of serious disease or injury or need for major surgery, I hereby give my permission for Emergency Treatment and release of my medical records. I understand that I am responsible for charges incurred and authorize release of medical information necessary to process medical claims.

DATE

SIGNATURE



Student Health Services
Strengthening learning through health and wellness


I understand that payment for services not covered by health fee or health insurance is my responsibility. If I am unable to pay, I understand the charges will be placed on my OASIS account and I will be placed on administrative hold. This hold will immediately be removed upon payment of the outstanding balance at the Cashiers Office, ADM 131, 9am to 5pm (A 24-hour drop box is also available.)



U -

Print Name: _____

Signature: _____ Date: _____

Street Address	City	State/Zip Code
Email Address	Phone Number	Date of Birth

Do you have health insurance? Yes (please continue) No 

Insurance Company Name	Subscriber/Policy #	Group #
Are you the subscriber?	<input type="checkbox"/> Yes  <input type="checkbox"/> No (please continue)	
Subscriber Relationship:	<input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> spouse <input type="checkbox"/> other	
Subscriber Last /Family Name (if not self)	Subscriber First/Given Name	
Street Address	City	State/Zip Code
Subscriber SSN	Phone Number	Date of Birth
Employer Name	Do you have your insurance card (or a copy)? <input type="checkbox"/> Yes  <input type="checkbox"/> No (please continue)	
Claims Address	City	State/Zip Code
Customer Service Phone Number		

***If you are insured by Tricare, please present both your military ID & Tricare Insurance card**

UNIVERSITY OF SOUTH FLORIDA COLLEGES OF MEDICINE AND NURSING
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Version of Notice of Privacy Practices Provided: 04/14/2003

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

Signature of Patient (or Authorized Personal Representative)

Date

Print Name of Patient (or Authorized Personal Representative)

Authority of Personal
Representative (e.g. parent,
legal guardian, health care
surrogate)

DOCUMENTATION OF GOOD FAITH EFFORTS
TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The patient presented for his/her service on this date and was provided a copy of the USF Colleges of Medicine and Nursing Notice of Privacy Practices (Notice). A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgement of receipt was not obtained because of the following reason(s):

- Patient refused to sign the Acknowledgement of Receipt.
- Patient was unable to sign or initial the Acknowledgement of Receipt.
- There was a medical emergency, and an attempt will to obtain an Acknowledgement of Receipt at the next available opportunity.

Signature of employee completing the form

Date

Print Name of employee

Affix Patient Label:

Privacy Practices

UNIVERSITY OF SOUTH FLORIDA COLLEGES OF MEDICINE AND NURSING NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

This notice describes how medical information about you may be used and disclosed, and how you can get access to the information. Please review it carefully.

Introduction: Parts of the University of South Florida (USF) provide health care to patients, provide operational support for such services or bill for such services electronically. These parts include the College of Medicine, the College of Nursing, USF Medical Services Support Corporation (MSSC), and University Medical Service Association, Inc. (UMSA). Together, all of these entities and their faculty, staff, students and other trainees are referred to throughout this Notice as the "USF Physicians Group," "Group," "we," "us," and "our." The Group includes physicians, nurses and other healthcare professionals who are faculty, staff or trainees; medical students, nursing students, and other healthcare students; and staff who provide support to our patient care, teaching and research mission.

This notice will tell you about the ways in which the Group may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to make sure that medical information that identifies you is kept private; to give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. This notice applies to all of the records of your care maintained by the Group. A copy of our current notice is posted in each of our clinical sites. You can obtain an additional copy by accessing our website at www.usfdocs.com, calling the USFPG Ambulatory Operations at the number listed at the end of this Notice, or asking for one at the time of your next visit.

Our pledge regarding your medical information: We value the trust you have placed in us to provide your health care. In keeping with our commitment to provide the highest quality of patient care with a profound sense of caring, we are committed to treating all the information you give us responsibly. We promise to treat your personal health information as private and follow the laws applicable to the privacy of health information used in providing your care, in our teaching activities, and in our research studies.

Who will follow this notice: All physicians, faculty, employees, trainees, volunteers and other personnel of the Group, and any USF administrative personnel when they are using and disclosing patients' health information in support of the Group.

Where this notice applies: This notice applies to all clinics and physician offices owned or leased by, or under contract with, the Group; and at other affiliated clinical practice sites where this notice is distributed.

Information we collect: We create a record of your medical conditions and of the care and services we provide to you at clinics and doctors' offices owned or leased by, or under contract with, the Group. We need this record to provide you with quality care and to comply with the law. We also compile information about charges and bills for services we provide to you and about your payment for those services, or payment made on your behalf by your health plan or health insurance company.

How we may use and disclose your health information: The following categories describe routine ways that we can use and disclose your health information. For each category we give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use your health information to treat you and to coordinate and arrange services for you. Your health information will be shared with doctors, nurses, technicians, medical students and other healthcare trainees, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken bone may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the Group also may share medical information about you in order to coordinate the different things you need, such as lab work and x-rays. We also may disclose medical information about you to people outside the Group who may be involved in your medical care, such as a doctor or another provider you are seeing who does not work for the Group.

For Payment. We may use and release your health information to bill and collect payment for services we provide to you. For example, we may need to give your health plan or health insurance company information about surgery we performed so your health plan will pay us or reimburse you for the surgery. We may share your health information to verify your health plan benefits. For example, we may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose your health information for our business operations and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients to decide what additional services to offer, what services are not needed, and whether certain new treatments are effective. We also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the health information we have with health information from other medical groups to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also share your information with other health care providers and health plans that serve you, if they need your information to conduct their own business operations.

Appointment Reminders, Treatment Alternatives, Benefits and Services. In the course of providing health care services to you, we may use your health information to contact you with a reminder that you have an appointment. Communications such as newsletters or announcements of support group activity or educational services provided may be sent to you. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you. You may choose not to receive certain communications by contacting the USFPG Ambulatory Operations at the number listed at the end of this Notice.

Fundraising. USF and its Foundation may use demographic information about you, including information about your age and gender, where you live or work, and the dates that you received treatment, in order to contact you to raise funds in support of the University. We will obtain your consent prior to sharing information about you in this manner. You may choose not to receive future fundraising communications by contacting the USFPG Ambulatory Operations Administration at the number listed at the end of this Notice.

Individuals Involved in Your Care or Payment for Your Care. We may release your health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an agency (like the Red Cross) that is assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. The Group is a medical practice that is associated with the School of Medicine of the University of South Florida, and medical research is an important part of our mission. Your medical information may be used or disclosed for research purposes. In certain cases, your specific written authorization will be necessary. In some cases, where the risk to you has been found by USF to be very low, USF may allow researchers to use your medical information to do research without getting your written authorization. In other cases, your medical information may be reviewed by researchers in order for them to prepare a research project or to see if you are eligible to participate in research projects. Your information may be used for research in a way that does not specifically identify you. Finally, the law allows us to use some very limited information about you for research and public health studies and to give it to other health care providers and health researchers for their own research and operations, but only if they pledge not ever to use the information to identify you.

As Required By Law. We will disclose your health information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or lessen the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation. If you are an organ donor, we may disclose health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to arrange organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the United States Armed Forces, we may disclose your health information as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your health information for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Activities. We may disclose your health information to authorized public health officials, or a foreign government agency collaborating with such officials, so they may carry out their public health activities. For example, we may share your health information with government officials responsible for controlling disease, injury or disability, such as the Florida Department of Health or the United States Centers for Disease Control and Prevention, or for other permitted public health purposes. If you have a communicable disease, we may also share your information with others who may have been exposed to your illness, if the law either allows us or directs us to do that to protect other people.

Health Oversight, Licensing, Accreditation and Regulatory Activities. We may disclose your health information to health oversight agencies authorized to conduct audits, investigations, and inspections of our facilities. These government agencies monitor the operation of the health care system, the licensing of health care providers in Florida (Agency for Health Care Administration), government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs, drug and device safety laws, and civil rights laws. We may also disclose your information to any agency that reviews our operations, such as the Accreditation Council for Graduate Medical Education, and to persons and companies regulated by the Food and Drug Administration (FDA) in order to tell them about the effects of any products they make or use.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court or an administrative hearing officer that is handling a lawsuit or other dispute or if we receive a valid subpoena that requires us to turn over your records.

Law Enforcement. We may disclose your identity and your other protected health information to law enforcement officials for the following purposes:

- In response to a court order or as required by law;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, material witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interest;
- If we suspect your death may be the result of criminal conduct; or

- If necessary to report a crime on our property or crimes discovered or witnessed by our staff.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also disclose this information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President of the United States or other officials.

Inmates and Correctional Institutions. If you are an inmate of a correctional institution or in the lawful custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official, if necessary to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

Uses and disclosures with your written authorization. We may need to obtain your written authorization before using or disclosing your health information for other purposes or for sharing it with others outside our Group. You may also initiate the transfer of your records to another person by filling out and signing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the USFPG Ambulatory Operations Administration.

Victims of Abuse, Neglect or Domestic Violence. We may release your health information to a public health authority or agency that receives reports of abuse, neglect or domestic violence. We will try to tell you about this before we release your information for these purposes, but in some cases we may need to act without getting your permission.

Special Protections for Mental Health, Substance Abuse or HIV Information. Special privacy protections apply to mental health, substance abuse or AIDS/HIV related information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your records involve such information, the information will be handled, used and disclosed only as permitted by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. To inspect or obtain a copy of your health information, please write to the USFPG Ambulatory Operations Administration at the address listed at the end of this Notice. You should request an Access Request Form. When completing the form, your request should state the specific requested information and the time period to which it relates. Should you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request.

We will ordinarily respond to your request within 30 days if the information is located in our facility, and within 60 days if it is located off-site at another facility. Should we need additional time to respond, we will notify you to explain the reason for the delay and to provide a time frame for when you can expect an answer to your request.

Under certain circumstances, we may deny your request to inspect or obtain a copy of your information, for example, during your participation in a research study. If we deny your request, we will provide a written denial notice that identifies our reasons for the denial, explains your rights to have that decision reviewed and how you can exercise those rights, and includes information on how to file a complaint about these issues with us or with the United States Department of Health and Human Services.

Right to Amend. If you believe that the health information we have about you is incorrect or incomplete, you have the right to ask us to amend the information as long as the information is kept in our records. To request an amendment, please write to the USFPG Ambulatory Operations Administration at the address listed at the end of this Notice. You should request a Medical Record Correction/Amendment Form. When completing the Form, you should include the reasons why you think we should make the amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing to explain the reason for the delay and when you can expect to have a final answer to your request.

We may deny your request if you ask us to amend information that was not created by us; is not part of the health information kept by us; is not part of the information which you would be permitted to inspect and copy; or is accurate. Should we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision to deny an amendment, you will have an opportunity to submit a statement explaining your disagreement, and we will include this statement in your records. We will also include information on how to file a complaint with us or with the United States Department of Health and Human Services.

Right to an Accounting of Disclosures. You have a right to request and receive an accounting of disclosures of your protected health information in the six years prior to the date on which the accounting is requested. The accounting will identify certain other persons or organizations to whom we have disclosed your health information. Any accounting includes only disclosures, and will not include uses of your information.

In addition, we are not required to provide an accounting of the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made after obtaining your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made from the patient directory;
- Disclosures made to persons involved in your care or payment for your care, or for other notification purposes;
- Disclosures that were incidental to permissible uses and disclosures of your health information;
- Disclosures for purposes of research, public health or our business operations where your protected health information has been partially de-identified so that it does not directly identify you;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officers about individuals in their lawful custody;
- Disclosures made before April 14, 2003.
- Disclosures for certain research purposes, as permitted by law.

To request an accounting of disclosures, please write to the USFPG Ambulatory Operations Administration at the address listed at the end of this Notice. You should request an Accounting for Disclosures Request Form. When completing the form, your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. You have a right to receive one accounting within every 12-month period at no cost. However, we may charge you for the cost of providing any additional accountings. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. We may delay providing you with an accounting without notifying you if a law enforcement official or government agency asks us to do so.

Right to Request Additional Privacy Protections. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or conduct our or another health care entity's business operations. You may also request that we limit how we disclose information about you to persons involved in your care. To request a restriction, please write to the USFPG Ambulatory Operations Administration at the address listed at the end of this Notice. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we disclose it to others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction. We will notify you when doing so. If we do agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communications. You have a right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at an alternative location. We will accommodate reasonable requests. It is critical, however, that we have the ability to reach you by telephone. You may request a confidential communication upon check in at your next visit, or you may make your request in writing to the USFPG Ambulatory Operations Administration at the address listed at the end of this Notice. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

Right to a Paper Copy of This Notice. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You can obtain an additional copy by accessing our website at www.usfdocs.com, calling the USFPG Ambulatory Operations at the number listed at the end of this Notice, or asking for one at the time of your next visit.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our clinic entrance areas. The notice will contain the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Group or with the Secretary of the Department of Health and Human Services. To file a complaint with the Group, write to the USFPG Ambulatory Operations Administration at the address listed at the end of this Notice. You will not be penalized or retaliated against for filing a complaint.

How to contact us:

If you have any questions about this notice, please contact our Privacy Officer at (813) 974-8090.
 All correspondence to the USFPG Ambulatory Operations Administration should be directed to the following address:
 USFPG Ambulatory Operations Administration
 Attention: Quality Management Office
 12901 N. Bruce B. Downs Blvd., MDC 33
 Tampa, Florida 33612 (813) 974-2201