Student **Health** Services

University of South Carolina

TREATMENT AGREEMENT &
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Information

Patient Name:_____ Date of Birth:_____

USC ID and/or Last 4 of SSN:_____

CONSENT FOR TREATMENT/ CARE:

I hereby authorize any medical or mental health treatment for myself that may be advised or recommended by the health care providers of USC. I am aware that the practices of medicine and psychology are not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations, procedures, or analysis.

ACKNOWLEDGMENT:

I attest that this office has given me a copy of its Notice of Privacy Practices to review. The Notice describes how medical 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 a copy of its Notice on the first services encounter after August 25, 2013. 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 acknowledgment of receipt as soon as possible following the emergency.

CHECK ALL THAT ARE TRUE:

- ☐ I have reviewed USC's Notice of Privacy Practices.
- ☐ The health care provider/agent has given me the chance to discuss my concerns and questions about the privacy of my health information.

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

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USC INTERNAL STAFF USE ONLY

COMPLETE IF ACKNOWLEDGMENT 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