Longwood University Health Center
106 Midtown Avenue . Farmville VA 23901
office 434.395.2102 fax 434.395.2783
email: studenthealth@longwood.edu

Potomac Healthcare Solutions℠

Required Submission of Health Record of University Students

In accordance with the Commonwealth of Virginia and the American College of Health Association Immunization guidelines, Longwood University policy requires that all full time students enrolling for the first time in any four-year public institution of higher education in the Commonwealth must have a health history on file in the Longwood University Health Center on a Health Wellness Form.

All other registered students who are not employees and pay the comprehensive fee must also have a complete Health Wellness Form on file (e.g. part-time, graduate, international/exchange visiting students).

This policy helps ensure the health of all students by reducing the possibility of communicable disease on the Longwood University Campus. Any student not providing such record will be restricted from registering for their second semester course, per Longwood University policy.

You may be asked to update this information on an annual basis.

Patient's Permission to treat

Name:_____ Date of Birth: _____
Last First MI

Over 18:
I hereby give the Longwood University Health Center / Potomac Healthcare Solutions, LLC permission to treat me whenever I present myself to the health center.

Patient signature _____ Date: _____

Under 18:
I/We, the parents of _____ hereby give the Longwood University Health Center / Potomac Healthcare Solutions, LLC permission to treat my/our child whenever they present to the health center.

Parent/Guardian Signature: _____ Date: _____

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DEMOGRAPHIC INFORMATION

Today's date: _____

Name:_____ Date of Birth: _____
Last First Middle
Nickname: _____ Gender:_____ Pronouns: _____
Address:_____ __ Single __ Married __ Divorced
City: _____ State: _____ Zip: _____
Home: (___)____-_____ Mobile: (___)____-_____ Work: (___)____-_____
(Please add LUHC to your contacts on your mobile phone so you know we are calling and keep your voice mailbox maintained)

Email address:_____

Race: __American Indian/Alaska Native __ Hispanic __ Black/African American __ Asian __ White
__ Native Hawaiian/other Pacific Islander __ Other _____ __ Decline to report

Ethnicity: __ Hispanic/Latino __ Not Hispanic/Latino __ Decline to report

Emergency contact:_____ Relationship_____
Emergency contact number: (___)____-_____

E-PRESCRIBING CONSENT

Preferred pharmacy: __ Farmville Family Pharmacy __ Walgreen's __ Walmart __ CVS

I understand that LUHC/Potomac Healthcare Solutions, LLC has implemented e-prescribing for its patients. I also understand that e-prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need for a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone and fax. E-Prescriptions are fast, convenient, legible, secure, cost effective and safe. The e-prescribing process also allows the health care provider to access critically important information about their patient's current and past medications from pharmacy benefit managers, community pharmacies, and the Virginia Prescription Monitoring System. This information helps alert the provider to other potential medication issues with their patients and can improve safety and quality.

I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to LUHC/Potomac Healthcare Solutions LLC requesting and using my medication history form other health care providers or third party pharmacy benefit payors and the Virginia Prescription Monitoring System for treatment purposes.

_____ _____
Patient/Responsible Party Signature Date

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RESPONSIBLE PARTY
(complete if other than yourself)

Name of Guarantor: _____ Relationship to patient:_____
Address:_____
City: _____ State: _____ Zip: _____
Home: (___)____-_____ Mobile: (___)____-_____ Work: (___)____-_____

INSURANCE INFORMATION
(complete if not providing a copy of insurance card(s))

Primary
Ins Co Name: _____ Policy/Member ID#: _____
Patient Relation to Insured: __ Self __ Spouse __Child __Other: _____
Policy Holder Name: _____ Gender: _____
Insurance address: _____ City _____ Zip _____

Secondary
Ins Co Name: _____ Policy/Member ID#: _____
Patient Relation to Insured: __ Self __ Spouse __Child __Other: _____
Policy Holder Name: _____ Gender: _____
Insurance address: _____ City _____ Zip _____

PATIENT/GUARANTOR RESPONSIBILITIES

Diagnostic testing: We recommend that you call your insurance carrier to be informed of your benefits for any diagnostic tests that the health center may order for you. You should inquire if pre-authorization is needed. If so, you will need to contact our office prior to your scheduled appointment to avoid claim denial.

Financial Policy: To ensure accurate claim filing, please give your most current insurance card to our front office to be copied. Potomac Healthcare Solutions, LLC participates with most managed care plans. We will beill your insurance company in compliance with the guidelines of our contract. If you do not have health insurance, please indicate above. Random audits may be completed to ensure the accuracy reported information.

I hereby authorize Potomac Healthcare Solutions, LLC to provide me with medical treatment. I understand and agree that I am responsible for all fees not covered by my insurance company. I hereby authorize the release of any medical information necessary to file a claim with my insurance company. I understand that an refusal or misrepresentation of my insurance coverage may result in a balance for services rendered.

_____ _____
Patient/Responsible Party Signature Date

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Name: _____ DOB: _____

PRIVACY POLICY

Acknowledgement of Receipt of the Notice of Privacy Practices

I understand and have been provided with the Notice of Privacy Practices that provides a detailed description of medical information uses and disclosures. If completing this form prior to arrival for my first visit, I am aware that this is available for review at the front desk and on the website.

I understand that I have the right to review the notice prior to signing this acknowledgement form.

I understand that Potomac Healthcare Solutions, LLC reserves the right to change their notice and practices. The change will be posted in the Health Center and available to me on the Longwood website.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Potomac Healthcare Solutions, LLC is not required to agree to the restrictions requested.

I understand that I may revoke this acknowledgement in writing, except to the extent that Potomac Healthcare Solutions, LLC has already taken action in the reliance thereon.

_____ _____

Patient/Representative Date

Representative relationship to patient _____

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Name: _____ DOB: _____

2 HOUR CANCELATION AND "NO SHOW" POLICY

As a participant at LUHC, it is your responsibility to keep record of your scheduled appointment. If you are unable to make a scheduled appointment we request that you cancel or reschedule at a minimum of 2 hours in advance. You can cancel or reschedule your appointment by calling the center at 434.395.2102 or coming by the health center.

A **NO SHOW** is when a patient does not show for a scheduled appointment without cancellinr or rescheduling the appointment.

If a patient establishes a pattern of cancellations or rescheduled appointment and/or no shows, they will receive an email (faculty/staff) or secure message (student) or phone call for LUHC asking them to make an appointment with the Director before services can resume. If the pattern continues, then there will be a fee of $25 charge to the patients account for each reoccurrence.

By signing below I acknowledge that I understand this policy.

_____ _____

Patient Date