1785

The University of Georgia®

Student Affairs
University Health Center

February 6, 2013

Dear Department Head or Faculty Member:

The University Health Center is a campus resource for acute health care needs of school-aged and teenage students who are enrolled in campus sport and educational summer camps. During summer semester, we are open from 8am -12pm, and 1pm-5pm, Monday through Friday. We look forward to providing quality health care for your campers with urgent illnesses and acute injuries as a way of supporting your summer camp/program.

UHC does charge a fee for services rendered, and payment is due at the time of service. UHC can bill the camper's insurance policy for services we provide as a courtesy, but we will still request payment from the camper at the time of service. UHC is not a participating provider nor contracted with any insurance plan or HMO. We do not accept Medicaid and will not file Medicaid insurance.

If you request that we provide care to students enrolled in your summer camp/program, we require the following information:

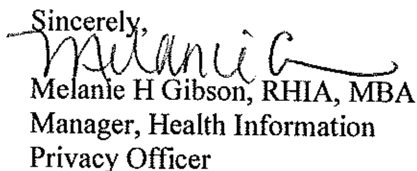
1. Camp name and dates, UGA Program contact and campus location information.
2. A list of enrolled campers with First Name, Last Name, and Date of Birth, faxed to UHC Patient Registration, 706-542-4959.
3. Completed Health Care Billing Procedure Request Form for Summer Programs, faxed to UHC Business Services, 706-542-0217.
4. Completed UHC Health Form for Special Program for each camper, with signature of the parent/guardian giving us permission to treat the minor child. We cannot accept other health forms or copies of other records in lieu of this form. (form attached). Send by campus mail, USPS mail, or hand deliver to Melanie Gibson, Patient Registration, University Health Center, University of Georgia, Athens GA 30602.

If you choose not to use the University Health Center as a resource for your campers' healthcare, there are a number of other healthcare resources in Athens you may consider using, for example:

1. Athens Regional First Care, multiple offices
2. Reddy Clinic
3. Athens Orthopedic Clinic Urgent Care
4. St Mary's Hospital Emergency Department
5. Athens Regional Medical Center Emergency Department

Your assistance in this matter is greatly appreciated. Should there be any questions, please contact me at 542-8618 or Shannon Kuykendall in our Business Office at 542-8638.

Sincerely,



Melanie H Gibson, RHIA, MBA
Manager, Health Information
Privacy Officer

Athens, Georgia 30602-1755 • Telephone 706-542-1162 • Fax 706-542-4959
An Equal Opportunity/Affirmative Action Institution

UNIVERSITY HEALTH CENTER
The University of Georgia
Athens, GA 30602-1755
(706) 542-1162
www.uhs.uga.edu

HEALTH FORM for 2013 SUMMER CAMPS and PROGRAMS

This form is required for treatment at the University Health Center if the participant should become ill or injured while on campus. FAX to 706-542-4959 prior to camp/program. Please note, there will be charges for services provided by the University Health Center.

NAME ______________________________ DATE OF BIRTH __________

HOME STREET ADDRESS ______________________________

CITY, STATE, ZIP CODE ______________________________ GENDER ______

PROGRAM ______________________________ PHONE (____) __________

PROGRAM CONTACT PERSON ______________________________ PHONE (____) __________

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES

I hereby authorize the physicians of the University Health Center, their agents or consultants, to perform diagnostic and treatment procedures on (Name)__________________, which, in their judgment, may become necessary while he/she is a participant in (Program) __________________ between (Dates) __________________ at The University of Georgia.

Privacy Practice Acknowledgement: I understand that, under The Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). By signing below, I acknowledge that I have read and understand the University Health Center's Notice of Privacy Practices (Notice). It is posted on the University Health Center's website at www.uhs.uga.edu under About UHC, Confidentiality, Patient's Rights and Responsibilities. The University Health Center reserves the right to change the terms of its Notice of Privacy Practices. If such changes are made, I understand that the University Health Center will post a revised Notice on its web site at www.uhs.uga.edu. I also understand that the University Health Center will provide a Notice to me upon request.

PARTICIPANT (if over 18) ______________________________ DATE __________

PARENT/GUARDIAN (if under 18) ______________________________ DATE __________

PERSONS TO NOTIFY IN AN EMERGENCY SITUATION

1. Name ______________________________ Relationship __________

   Address ______________________________
   Street Number and Name City State Zip Code

   Work Phone __________________ Home Phone __________________

   Cell Phone __________________ E-mail Address __________________

2. Name ______________________________ Relationship __________

   Address ______________________________
   Street Number and Name City State Zip Code

   Work Phone __________________ Home Phone __________________

   Cell Phone __________________ E-mail Address __________________

Date of last Tetanus shot __________________

Current medications ______________________________

Allergies to medications ______________________________

Chronic or significant medical conditions ______________________________

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PRIMARY INSURANCE INFORMATION Please complete if you wish UHC to file for reimbursement from your insurance company. Providing this information does not guarantee payment of your claim by your insurance company. You are responsible for any charges for services rendered. (Please attach a copy of the front and back of your insurance card.)

Please check appropriate boxes below:

Medical: _____ HMO _____ PPO _____ POS _____ Other _____ **Dental** _____ **Prescription**

Policyholder's name: ______________________________
Insured is: Self Parent/Responsible Party Third Party Your Relationship to Insured ______________

Medical Insurance Company Name: ______________________________

Insurance Company Street Address: ______________________________

Insurance Company City: ______________________ State: ________ Zip Code: ____________

Telephone Number: ______________________________

Policy Number: ______________________ Group Number: ______________________

PARENT/RESPONSIBLE PARTY/THIRD PARTY INFORMATION - Name of Insured/Policyholder: (i.e., parent, step-parent, spouse)
Name: ______________________ E-mail Address: ______________________

Address: ______________________________

City: ______________________ State: ____________ Zip Code: ____________

Telephone Number: Home: ______________ Work: ______________ Cell: ______________

Date of Birth: ______________ M ___ F ___
Marital Status: Single Married Domestic Partner Divorced Separated Widowed

Place of Employment: ______________________________ Full Time Part Time

Employer Address: ______________________________

City: ______________________ State: ____________ Zip Code: ____________

AUTHORIZATION TO PROCESS INSURANCE CLAIMS

The University Health Center (UHC) will attempt to file insurance claims on behalf of patients and clients. **The filing of claims does not guarantee either full or partial payment by the insurance company.**

The UHC is a participating provider only for the Student Health Insurance plan available to UGA students. The UHC is not a participating provider for other health insurance plans, including those covering state employees and their dependents. Students and their parents are encouraged to contact their insurance company to request that the UHC be enrolled as a participating provider in their plan.

The UHC Pharmacy is approved to file claims on most insurance plans for prescriptions, whether written by UHC providers or others. Students are urged to check with the UHC Pharmacy staff to see if their policy is covered before attempting to fill prescriptions elsewhere.

I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company which is necessary to process insurance claims for services rendered by this facility. I hereby authorize my insurance company to distribute the payment of my (or my dependents) medical coverage directly to the provider rendering services. **I understand that I am fully responsible for all charges regardless of my insurance benefits.** I authorize the use of this signature on all insurance submissions. I may elect to pay any bill in full in lieu of submitting a claim for insurance reimbursement.

Signature: ______________________________ Date ______________________
(Student)

Signature: ______________________________ Date ______________________
(Parent/guardian if a minor)

12/03
Revised: 9/22/06, 2/23/2010; 2/3/2011; 2/2012; 2/2013

For Office Use Only:
Date Received: ____________
Received by: ____________
Entered by: ____________

The University Health Center
The University of Georgia
Athens, GA 30602-1755
706-542-8621 Business Office
706-583-0217 Facsimile

UGA SPONSORED SUMMER CAMP
Health Care Billing Procedure Request

Summer Camp/Clinic ______________________________

Session Date(s) ______________________________

Estimated Number of Participants per Session ______________________________

Sponsoring Department ______________________________

Telephone Number ______________ Contact Person ______________

Please indicate below which option your department prefers regarding billing and payment procedures for participants in your summer program.

Option:

_________ A. Parents are billed directly for 100% fee-for-service.

_________ B. As a sponsoring department, we agree to accept and pay for any charges incurred by a participant within our program.

As the individual responsible for the supervision and direction of the above listed program, I understand the above selection applies only to services available at the University Health Service.

Fax back to : 706-583-0217

____
Signature

____
Title

____
Date

2/2013