Center for Student Wellness

Consent to Treatment (EMPLOYEE USE ONLY)

Employee name: _____

Date of Birth: _____ Employee ID: _____

Date of Initial Visit: _____

1. I voluntarily seek and consent to treatment at the Center for Student Wellness Health Services (Center). I am aware that these practices are not exact sciences and no guarantees are being made to me regarding the outcomes of the treatment being provided.
2. I understand that the services being offered through the Center for Student Wellness are a courtesy and that the provider may recommend that I set an appointment with my primary care provider for initial treatment and/or follow-up. I understand that these services are not being offered as a replacement for regularly scheduled visits and that the SBU CSW provider may not be able to treat the condition(s) with which I am presenting at the Center. The SBU CSW provider reserves the right to make referrals to a patient's primary care provider in the event that the condition is outside the scope of the provider's practice.
3. Due to a limited number of appointment times on any given day, the Center is unable to guarantee same-day service for walk-in appointments. Every effort will be made to accommodate an employee's request to be seen the same day. Students will be given preference in the event that an employee and student arrive as walk-ins at the same time. Employees will then be offered the next available appointment time or be scheduled at a later date.
4. I agree to provide the Center with any information of a medical, social, or psychological nature that may be required for my treatment. I understand that my information is protected under federal privacy laws and will only be released with my consent or within confidentiality limits as provided in federal and state laws.
5. I understand that there are limits to confidentiality in certain circumstances which would require the health care provider to release my information without my written consent. These circumstances include:
    a. If I am in immediate danger to myself or others and not releasing the information would further jeopardize my safety or the safety of others;
    b. In the event that I have knowledge of child abuse and I divulge this knowledge to my health care provider;
    c. In the event that my health care provider is ordered by a court of law to turn over my chart.
6. I am aware that the Center is not responsible for any personal property that I bring onto the premises. Anything that is lost, stolen, or broken is fully my responsibility.
7. I authorize the ANONYMOUS use of my records for teaching and/or research purposes. All confidential information in my file will be blacked out or otherwise unavailable to third parties unless I sign a consent releasing additional information.
8. I understand that any recommendations made by the Center staff are for my care and welfare. I understand that should I choose or fail to follow these recommendations I am implicitly taking responsibility for any outcomes resulting therefrom, and hereby waive any and all claims, causes of action, or the like against the University and the Center for Student Wellness along with any agents or employees thereof.

☐ Copy accepted ☐ Copy Declined

Signature of Patient: _____ Date/Time: _____

Signature of Witness: _____ Date/Time: _____