

CAMPUS HEALTH

Please remit completed form to:
Patient Accounts
Campus Health
James A. Taylor Building, CB#7470
Chapel Hill, NC 27599

CAMPUS HEALTH APPLICATION FOR SERVICES

*Please print clearly and complete all fields

Applicant's Name _____
Last First MI

Mailing Address _____

PID _____ Telephone # _____ Birthdate ____/____/____

Department Name _____ Appointment Effective Date ____/____/____

I have attached the required information on my medical history.

REQUEST FOR OPTIONAL SPOUSAL/DOMESTIC PARTNER COVERAGE

I request enrollment in the Campus Health Pre-Paid Health Care Plan for my spouse and certify that I am legally married to or a partner of _____

Applicant's Signature _____ Date _____

APPLICATION FOR SPOUSAL/DOMESTIC PARTNER COVERAGE

Name _____
Last First MI

Mailing Address _____

PID _____ Telephone #. _____ Birthdate ____/____/____

In addition to the premium for the BlueCross BlueShield of North Carolina Student Blue plan the monthly 2019-2020 health fee of \$41.68 is also required.

Applicant's Signature _____ Date _____

Name: _____ Date of Birth: _____
 Last First Middle/Maiden MM/DD/YYYY

UNC PID#: _____ Preferred Phone: Cell Home _____ Email: _____

Address: _____

Postdoctoral Spouse Year Entering UNC: _____ Semester: Fall Spring

Previously enrolled at UNC Chapel Hill? No Yes International Student: No Yes - Country of Origin _____

Name of person to contact in case of emergency _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____ Phone Number _____

Family, Personal and Social History

Has any person, related by blood, had any of the following? If you prefer not to answer, please leave blank.

	Yes	No	Unknown		Yes	No	Unknown		Yes	No	Unknown
High blood pressure				Cholesterol or blood fat disorder				Cancer (type):			
Stroke				Diabetes				Alcohol/drug problems			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder								Suicide			

Have you ever had or have you now: (if yes, indicate year of first occurrence). If you prefer not to answer, please leave blank.

	Yes	No	Year		Yes	No	Year		Yes	No	Year
ADD/ADHD				Disordered Eating				Mononucleosis			
Allergy Injections				Endocrine Issues				Neurologic Disorders			
Asthma				Gastrointestinal Issues				Psychiatric Disorders (Anxiety, Depression)			
Other Respiratory Problems				Gynecologic Issue				Other Psychiatric Disorders			
Autoimmune Disorders				Headaches/Migraines				Rheumatologic Disorders			
Blood Disorders (anemia, sickle cell)				Hearing Problems				Substance/Alcohol Abuse			
Bone, Joint or Mobility Issues				Heart Issues or Pain/Pressure in Chest				Tumor or Cancer			
Chickenpox				Hepatitis				Vision Problems			
Concussion or Traumatic Brain Injury				High Blood Pressure				Other:			
Diabetes				Kidney/Bladder Issues							

Please explain any positive (yes answers) _____

Medications - including birth control, allergy injections, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) used:

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Student Name: _____ PID#: _____

Adverse Reactions to:	No	Yes	Explanation
Antibiotics (please name)			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

Other Health Issues:	No	Yes	Explanation
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six - twelve months? (Please describe)			

Have you ever had or have you now: (if yes, indicate year of first occurrence). If you prefer not to answer, please leave blank.

	No	Yes	Year		No	Yes	Year
Received counseling for mental health concerns				Purposefully injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)			
Taken a prescribed medication for mental health concerns				Received treatment for alcohol or drug use			
Been hospitalized for mental health concerns				Experienced harassing, controlling and/or abusive behavior from another person			
Seriously considered attempting suicide							

Please indicate if and how often you engaged in these behaviors in the past 30 days. If you prefer not to answer, please leave blank.

	N/A	Never	Rarely	Sometimes	Regularly	Always
Wear a seat belt when in a car						
Regularly exercise 3-5 times per week						
Eat 5 or more servings of fruits and vegetables per day						
Use a condom or protective barrier during sexual activity						

Within the last 30 days, on how many days did you use:

	Never used	Have used, not in last 30 days	1-5 days	6-19 days	20+ days
Tobacco Use					
Alcohol (beer, wine, liquor)					
Marijuana (pot, weed, hashish, hash oil)					
Other drugs (illicit, opioid, hallucinogens)					

Do you have a health concern or condition that may need treatment during your time at UNC? No Yes

Do you have a mental health concern or condition that may need treatment during your time at UNC? No Yes

Printed Name/Signature

Date

CAMPUS HEALTH PATIENT AGREEMENT

Permission for Diagnostic and Treatment Procedures: I authorize Campus Health, their employees and consultants, to provide medical treatment and perform diagnostic procedures and services, which in their judgement may be medically necessary for my care. These may include the use of clinical photography as well as requesting and accessing information available from third party payors and other healthcare providers about my prescription medications, including my prescription medication history and medications that are covered by my insurance plan. I agree that I will be involved and engaged in my care and treatment. If I require specialized and/or emergency care, I will be referred to appropriate outside medical facilities or professionals. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of Campus Health.

Confidentiality: Medical and mental health information contained the Campus Health record is strictly confidential and may only be released to outside sources with written permission from the patient, by a court order, or when permitted by law. Confidentiality and privacy is protected in all Campus Health business relationships to prevent the exchange of any patient specific information without permission. In the instance where an outside medical provider orders lab tests or allergy injections for patients at Campus Health, the results or follow-up from those tests or visits will be relayed back to the ordering provider. In addition, if a Campus Health provider refers you to an outside provider; your records pertaining to that referral may also be released.

Notification: I authorize Campus Health to contact me via University e-mail to include, but not limited to, appointment reminders, immunization requirements, insurance claim inquiries, etc. I am aware that I may opt-out of receiving e-mail correspondence by calling (919) 966-2283. Because conventional email is inherently unsecured and the confidentiality of sensitive medical information cannot be assured, it is advised for matters that are sensitive in nature to contact Campus Health directly by calling 919-966-2281 or by sending a secure message through the patient portal at <https://healthyheels.unc.edu>. To Opt Out of appointment reminder text messages from Campus Health, please call 919-966-2283.

Financial Information and Authorization to Process Insurance Claims: All UNC students are required to have health insurance either through an individual policy or through their family policy. Campus Health will file insurance claims on behalf of patients. The filing of claims does not guarantee either full or partial payment by the insurance company. For more information about using insurance at Campus Health, please visit: <http://campushealth.unc.edu/charges-insurance/using-insurance-campus-health>. Please remember that the Campus Health Pharmacy and Student Stores Pharmacy is In-Network with virtually all domestic health insurance plans.

I, the undersigned, have read and understood the above information and authorize the release of any medical or insurance information to my insurance company and/or their agents, including but not limited to any plan administrator, pharmacy benefits manager, underwriter, or sponsor, which is necessary to process claims for services rendered by Campus Health. I hereby authorize my insurance company to distribute the payment of my coverage directly to Campus Health. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize Campus Health to place any unpaid charges on my student account at the Office of Student Accounts and University Receivables (SAUR). I understand the office of SAUR may place a registration hold on my account for any unpaid Campus Health charges. I understand I cannot use Title IV federal financial aid to pay Campus Health charges unless I have signed permission with the Office of Scholarship and Student Aid. If I am a student at UNC-Chapel Hill, I understand that I am responsible for any charges incurred by my spouse or partner if treated at Campus Health. 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.

I verify by my signing below I have read and understood the above information and give my permission as stated above.

Signature of Patient: _____ Date: _____

Printed Name of Patient: _____ PID#: _____

Signature of Parent/Guardian (If patient is under 18): _____ Date: _____

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Campus Health for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Campus Health. My "protected health information" means medical, billing and demographic information about me collected from me and created or received by Campus Health which relates to my past, present or future mental or physical condition. I understand that diagnosis or treatment of me by Campus Health may be conditioned upon my consent as evidenced by my signature on this document.

I understand that Campus Health may contact me via University e-mail to include, but not limited to, appointment reminders, insurance claim inquiries, etc. I am aware that I may opt-out of receiving e-mail correspondence by calling Campus Health at (919) 966-2283. Because conventional email is inherently unsecured and the confidentiality of sensitive medical information cannot be assured, it is advised for matters that are sensitive in nature to contact Campus Health directly by calling 919-966-2281 or by sending a secure message through the patient portal at <https://healthyheels.unc.edu>. To Opt Out of appointment reminder text messages from Campus Health, please call 919-966-2283.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Except as noted below, Campus Health is not required to agree to the restrictions that I may request. However, if Campus Health agrees to a restriction that I request, the restriction is binding on Campus Health. Campus Health is required, and will agree to restrict disclosure of PHI about me to my health insurer when the PHI is solely related to a health care item or service for which I have paid in full out of pocket.

I have the right to revoke this consent, in writing, at any time. The revocation will be effective upon receipt, except to the extent that Campus Health has taken action in reliance on this consent.

I understand I have a right to review Campus Health's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information about me that will occur in my treatment, payment of my bills or in the performance of health care operations of the Campus Health. The Notice of Privacy Practices for Campus Health is also provided in various locations including on the Campus Health website at campushealth.unc.edu. The Notice of Privacy Practices also describes my rights and the Campus Health's duties with respect to protected health information about me.

Campus Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the Campus Health's website, calling the Campus Health office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Patient Name

Patient Signature

Date



THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

DIVISION OF STUDENT AFFAIRS

CAMPUS HEALTH SERVICES
JAMES A. TAYLOR BUILDING
CAMPUS BOX 7470
CHAPEL HILL, NC 27599-7470

May 22, 2019

<http://campushealth.unc.edu>

To: Postdoctoral Fellows and Family Members who are eligible to use Campus Health:

The staff at Campus Health welcomes you to Carolina. We look forward to assisting you with any health and wellness needs while you are here on campus. To assist us in this endeavor, we ask that you complete the health history form and return it to us at the address above on the letterhead. Please mark this Attn: Patient Accounts.

It is also the policy of Campus Health that all incoming Postdoctoral Fellows and family members eligible for services at Campus Health meet recommended vaccine guidelines and be screened for tuberculosis (TB). Please complete the TB screening questionnaire enclosed in this packet and mail a copy to Campus Health along with your health history form and vaccination records. Alternatively, you can fax a copy to 919-966-0616. If you answer "yes" to any of the questions on the screening questionnaire, you need to EITHER be tested for a TB infection OR you may need to make an appointment to see a Campus Health provider to discuss your individual situation.

Acceptable TB screening tests include the TB blood test (e.g. QFT-G or T-spot) or a PPD/TST (Tuberculin Skin Test). This screening test must have been done within the past 12 months before coming to UNC. If you have had the blood test for TB or the TB skin test within the last year, please send the result to Campus Health. Also, if a PPD/TST was done, the test must have been performed in a United States facility and it must be documented in millimeters of induration to be considered valid.

If you have ever had a positive TB screening test, you will be required to schedule an appointment with a Campus Health medical provider and provide appropriate documentation. If you have had a positive TB blood test or skin test in the past and it was done in the US, you do NOT need another TB blood or skin test. However, you will need to have documentation that you had a chest x-ray after the positive TB test or you will need another chest x-ray. Again, this chest x-ray must have been done in a US facility.

If you cannot provide the results of the TB screening test, do not have a current TB screening test (within the 12 months), or if your current test was not done in a United States facility, please call 919-966-2281 and choose option 2 to schedule an appointment to get the test done at Campus Health. If you have any questions about this policy, please call 919-966-6573 and ask to speak with a nurse.

Sincerely,

Ken Pittman MHA FACHE
Executive Director for Campus Health Services

Tuberculosis (TB) Screening Questionnaire

Name: _____ DOB: _____ PID #: _____

Please complete and return to Campus Health along with the Immunization Form and signed Patient Agreement.

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? Yes No

Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) Yes No

- | | | | | |
|--------------------------|--------------------|------------------------|--------------------------|-----------------------------|
| Afghanistan | China | India | New Caledonia | Sri Lanka |
| Algeria | China, Hong Kong | Indonesia | Nicaragua | Sudan |
| Albania | China, Macao | Iraq | Niger | Suriname |
| Angola | Colombia | Kazakhstan | Nigeria | Swaziland (AKA Eswatini) |
| Anguilla | Comoros | Kenya | Niue | Syrian Arab Republic |
| Argentina | Congo | Kiribati | Northern Mariana Islands | Taiwan |
| Armenia | Cote d'Ivoire | Kuwait | Pakistan | Tajikistan |
| Azerbaijan | DR of Korea | Kyrgyzstan | Palau | Thailand |
| Bahamas | DR of Congo | Lao PDR | Panama | Timor-Leste |
| Bangladesh | Djibouti | Latvia | Papua New Guinea | Togo |
| Belarus | Dominican Republic | Lesotho | Paraguay | Tokelau |
| Belize | Ecuador | Liberia | Peru | Tunisia |
| Benin | El Salvador | Libyan Arab Jamahiriya | Philippines | Turkmenistan |
| Bhutan | Equatorial Guinea | Lithuania | Portugal | Tuvalu |
| Bolivia | Eritrea | Madagascar | Qatar | Uganda |
| Bosnia and Herzegovina | Ethiopia | Malawi | Republic of Korea | Ukraine |
| Botswana | Fiji | Malaysia | Republic of Moldova | United Republic of Tanzania |
| Brazil | French Polynesia | Maldives | Romania | Uruguay |
| Brunei Darussalam | Gabon | Mali | Russian Federation | Uzbekistan |
| Bulgaria | Gambia | Marshall Islands | Rwanda | Vanuatu |
| Burkina Faso | Georgia | Mauritania | Sao Tome and Principe | Venezuela |
| Burundi | Ghana | Mexico | Senegal | Viet Nam |
| Cabo Verde | Greenland | Micronesia | Serbia | Yemen |
| Cambodia | Guam | Mongolia | Sierra Leone | Zambia |
| Cameroon | Guatemala | Morocco | Singapore | Zimbabwe |
| Central African Republic | Guinea | Mozambique | Solomon Islands | |
| Chad | Guinea-Bissau | Myanmar | Somalia | |
| | Guyana | Namibia | South Africa | |
| | Haiti | Nauru | South Sudan | |
| | Honduras | Nepal | | |

Have you had frequent or prolonged visits (this usually means a cumulative time of one month) to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) Yes No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? Yes No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? Yes No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? Yes No

If the answer is YES to any of the above questions, Campus Health strongly recommends that you receive TB testing as soon as possible and forward that result to Campus Health or you can get a TB screening test at Campus Health once school starts.

If the answer to all of the above questions is NO, no further testing or further action is required, please submit this form to Campus Health along with the Immunization Form and Patient Agreement.