INDIANA UNIVERSITY
NORTHWEST
Campus Health and Wellness Center

Name:_____ Date:_____ Age:_____

REVIEW OF SYSTEMS:Please check any current symptoms you are having.

Constitutional
- ☐ Recent fevers/sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue/weakness

Respiratory
- ☐ Cough/Wheeze
- ☐ Coughing up blood
- ☐ Shortness of breath

Skin
- ☐ Rash
- ☐ Changing Mole

Eyes
- ☐ Change in vision
- ☐ Drainage/crusting
- ☐ Pain/redness

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Nausea/vomiting/diarrhea
- ☐ Blood in stool
- ☐ Pain in abdomen

Neurological
- ☐ Headaches
- ☐ Numbness/tingling

Ears/Nose/Throat
- ☐ Change in hearing
- ☐ Hay fever/allergies
- ☐ Trouble swallowing

Genito-urinary
- ☐ Pain/Blood with urinating
- ☐ Leaking/night urination
- ☐ Change in sexual function

Psychiatric
- ☐ Anxiety/stress
- ☐ Depression/suicide
- ☐ Problem sleeping
- ☐ ADHD
- ☐ Bipolar

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Swelling

Blood/lymphatics
- ☐ Unusual bruising/bleeding
- ☐ Pain/swelling

Other:_____

Medications: Please include dose (if known) and taken how many times a day

_____

_____

_____

_____

Medicine Allergies and reaction:_____

HEALTH MAINTENANCE:

Colonoscopy date:_____ Normal:_____ Abnormal:_____

Mammogram date:_____ Normal:_____ Abnormal:_____

Bone Density date:_____ Normal:_____ Abnormal:_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems

☐ Heart Disease	☐ High blood pressure	☐ High cholesterol
☐ Asthma	☐ COPD/Emphysema	☐ Thyroid problems
☐ Diabetes	☐ Kidney disease	☐ Cancer
☐ Abnormal Pap smears	☐ Prostate problems	☐ Other (describe below)

_____

SURGERIES: _____

_____

FAMILY HISTORY: Please identify any immediate family members with the following conditions:

Alcoholism_____ High cholesterol_____

Heart Disease_____ High blood pressure_____

Depression/Suicide_____ Stroke_____

Diabetes_____ Asthma/COPD_____

Other_____

SOCIAL HISTORY:

Tobacco Use:
Cigarettes Never☐ Quit date_____ Current smoker☐
Packs/day_____ Age began smoking_____
Other: Pipe☐ Cigar☐ Chew☐

Alcohol Use: Do you drink alcohol? No☐ Yes☐ Number of drinks/week_____
Sexual Activity: No☐ Yes☐ Method of birth control_____
Do you use recreational drugs: No☐ Yes☐ Type_____
Do you exercise? No☐ Yes☐ How often?_____

SOCIOECONOMICS: If a student, what is your major?_____
Occupation_____ Employer_____
Marital Status: Single☐ Married/Partner☐ Divorced☐ Widow☐
Partner's name_____

Health Concerns _____

_____

_____

_____

INDIANA UNIVERSITY
NORTHWEST

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PATIENT REGISTRATION FORM

Name_____ Date_____

Student ID#_____ Employee ID#_____

SSN#_____ Age_____ Date of Birth_____

Sex: ◯ Male ◯ Female Marital Status: ◯ M ◯ S ◯ W ◯ D

Address_____City_____State_____

Zip Code_____ Phone #_____

Are You Employed? ◯ Yes ◯ No

Are You a Student? ◯ Yes ◯ No

If Applicable, Employer's Information:

Name of Employer_____

Address_____

City_____ State_____

Phone_____ Ext_____

Emergency Contact:

Name_____ Phone #_____Relationship_____

INDIANA UNIVERSITY
NORTHWEST
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CONSENT FOR TREATMENT
FINANCIAL AGREEMENT

I consent to assessment and treatment of myself by the IU Northwest Campus Health and Wellness Center.

I understand that I am responsible for and agree to pay for all charges incurred, regardless of my insurance status. I understand that the IU Northwest Campus Health and Wellness Center will provide me with receipts and information needed to file for reimbursement with my insurance company upon request.

Print Patient Name _____

Patient Signature _____ Date _____

Do you have insurance? ◯ Yes ◯ No

INDIANA UNIVERSITY
NORTHWEST

CAMPUS HEALTH & WELLNESS CENTER

3400 Broadway
Gary, Indiana 46408
(219) 980-7520

I, _____, hereby authorize any
Print Name
employee from the Indiana University Northwest Campus Health and Wellness Center to leave any information with regards to appointments, test results, etc. in voice messages at the following telephone number.

_____
Signature

_____
Preferred telephone number

_____
Date

ACKNOWLEDGEMENT OF RECEIPT

INDIANA UNIVERSITY NORTHWEST CAMPUS HEALTH AND WELLNESS CENTER'S

NOTICE OF PRIVACY PRACTICES

I, _____ , do hereby acknowledge that on this date, _____ , have been offered a copy of Indiana University Northwest Campus Health and Wellness Center's Notice of Privacy Practices.

By signing below, I am signifying that I have been offered the Notice of Privacy Practices and its explanation of how Indiana University Northwest Campus Health and Wellness Center will use my personal health information in relation to treatment, payment and health care operations, as well as my rights regarding the management of this information.

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

_____

Student ID Number or Social Security Number

Indiana University Northwest Campus Health and Wellness Center

E-MAIL INFORMED CONSENT

Indiana University Northwest Campus Health and Wellness Center (IUN-CHWC) provides patients the opportunity to communicate with their providers and administrative services by e-mail. Transmitting confidential patient information by e-mail, however, has a number of risks, both general and specific, that patients should consider before using e-mail.

General e-mail risks:

- E-mail sent to and from IUN-CHWC is not a secure or confidential form of communication. Patients should refrain from sending personal information or asking sensitive questions pertaining to specific health conditions when communicating via e-mail.

- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.

- Recipients can forward e-mail messages to other recipients without the original sender's permission or knowledge.

- Users can easily misaddress an e-mail communication.

- E-mail is easier to falsify than handwritten or signed documents.

- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

Specific patient e-mail risks:

- E-mail containing information pertaining to a patient's diagnosis and/or treatment must be included in the patient's medical record. Thus, all individuals who have access to the medical record will have access to the e-mail messages.

- Patients using their employer's e-mail system should have no expectation of privacy in e-mail they send or receive at their place of employment. Thus, patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.

- If an employer read an employee's e-mail and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information, they may discriminate against the employee/patient. For example, they may fire the employee, not promote the employee, deny insurance coverage, and the like. In addition, the employee could suffer social stigma from the disclosure of such information.

- Patients have no way of anticipating how soon IUN-CHWC and its employees will respond to a particular e-mail. Although IUN-CHWC and its employees will endeavor to read and respond to e-mail promptly, IUN-CHWC cannot guarantee that any particular e-mail message will be read and responded to within any particular period of time. Physicians, nurses, and other health care workers rarely have time during consultations, appointments, staff meetings, meetings away from the facility, and meetings with patients and their families to continually monitor whether they have received e-mail. Thus, patients should not use e-mail in a medical emergency.

- Patients requesting educational or health information via the IUN-CHWC website should understand that their requests will be responded to as soon as reasonably possible. The IUN-CHWC staff responding to website requests serve the health center in other capacities.

These staff members may be fulfilling other commitments at the time of your request. As a result, your request may not be responded to within the desired timeframe. If your request is urgent or an emergency, then other means of communication (i.e., telephone, or in person) with IUN-CHWC should be utilized.

Conditions for the use of E-mail:

It is the IUN-CHWC policy that it will make all e-mail messages sent or received that concern the diagnosis or treatment of a patient part of that patient's medical record and will treat such e-mail messages with the same degree of confidentiality as afforded other portions of the medical record. IUN-CHWC will use reasonable means to protect the security and confidentiality of e-mail information. Because of the risks outlined above, IUN-CHWC cannot, however, guarantee the security and confidentiality of e-mail communication.

Thus, patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

- All e-mails to or from the patient concerning diagnosis and/or treatment will be made a part of the patient's medical record. As a part of the medical record, other individuals, such as other physicians, nurses, physical therapists, business operations personnel, and the like, and other entities, such as other healthcare providers and insurers, will have access to e-mail messages contained in medical records.

IUN-CHWC may forward e-mail messages within the facility as necessary for diagnosis, treatment, and reimbursement. IUN-CHWC will not, however, forward the e-mail outside the facility without the consent of the patient or as required by law.

- If the patient sends e-mail to IUN-CHWC, one of its physicians, another health care provider, or an administrative department, IUN-CHWC will endeavor to read the e-mail promptly and respond promptly, if warranted. However, IUN-CHWC can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. **Because IUN-CHWC cannot assure patients that recipients will read e-mail messages promptly, <u>patients must not use e-mail in a medical emergency.</u>**

- If a patient's e-mail requires or invites a response, and the recipient does not respond within a reasonable time, <u>the patient is responsible for following up to determine whether the intended recipient received the e-mail and when the recipient will respond</u>.

- Because some medical information is so sensitive that unauthorized disclosure can be very damaging, patients should not use e-mail for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.

- Because employees do not have a right of privacy in their employer's e-mail system, patients should not use their employer's e-mail system to transmit or receive confidential medical information.

- IUN-CHWC cannot guarantee that electronic communications will be private. IUN-CHWC will take reasonable steps to protect the confidentiality of patient e-mail but is not liable for improper disclosure of confidential information not caused by IUN-CHWC's negligence or misconduct.

- If the patient consents to the use of e-mail, he/she is responsible for informing IUN-CHWC of any types of information the patient does not want to be sent by e-mail other than those set out in *paragraph 3,* above.

- Patient is responsible for protecting his/her password or other means of access to e-mail sent or received from IUN-CHWC to protect confidentiality. IUN-CHWC is not liable for breaches of confidentiality caused by patient.

- **Any further use of e-mail by the patient that discusses diagnosis or treatment by the patient constitutes informed consent to the foregoing.** You may withdraw consent to the use of e-mail at any time by e- mail or written communication to IUN-CHWC receptionist.

By signing below I acknowledge that I have been fully informed of the risks associated when communicating protected health information (PHI) via e-mail. Having been fully informed, I am ***providing my consent*** *for PHI to be communicated between me and my IUN-CHWC provider via e-mail. I also signify I have been offered a copy of the E-Mail Informed Consent form.*

_____ _____

Patient's signature Date

_____

Patient's printed name

Having reviewed the risks associated with e-mail use, I ***chose to decline*** *authorization of PHI communication via e-mail. I understand the IUN-CHWC is not liable for any e-mail communications I initiate. In the event I wish to consent to communicating PHI via email, I will present to the IUN-CHWC and sign the consent.*

_____ _____

Patient's signature Date

_____

Patient's printed name