UNIVERSITY OF TORONTO

HEALTH & WELLNESS CENTRE
EMERGENCY CONTACT FORM

Patient name:_____ Date:_____

(MM/DD/YYYY)

Student No:_____

Please provide us with your emergency contact information. This person is to be contacted <u>ONLY</u> in case of emergency. **PLEASE PRINT**

1. First Name:_____ Last Name:_____
2. Relationship:_____
3. Telephone Number:(_____) _____
4. Current Address:_____
5. City/Province/Postal Code:_____

Family Doctor Information:

Name: _____

Address: _____

Phone Number: _____

UNIVERSITY OF TORONTO

HEALTH & WELLNESS CENTRE
PRIVACY/CONFIDENTIALITY & PERMISSION TO SHARE INFORMATION

Please fill in the following information about yourself:

STUDENT INFORMATION		
Last Name	**First Name**	**Student #**

The University follows an integrated approach to your health and wellness, where the right services are made available according to your needs. These can include medical, counseling, help in crisis and assistance with academic accommodation. The University will hold information about you in confidence and will share this information only with others involved in your health care.

Services you may be involved with might be Health and Wellness Centre, Accessibility Services, Student Crisis Response, Student Academic Progress, Community Safety, University Residences/Housing and your University Registrar.

By signing below, you permit University student support services to share your information to work as a team and provide you with the most complete assistance we can.

Your information will be treated as confidential by our team and will only be shared on a need to know basis.

You do not have to sign to receive services and if you like, you can withdraw your consent at any time by advising us.

☐ I wish to limit this authorization to be in effect from _____ (month, year) to _____ (month, year)
☐ I wish for only certain types of information to be released, specifically:

_____
_____

X _____ **Date:** _____
Student Signature (MM/DD/YYYY)

X _____ **Date:** _____
Witness Signature (MM/DD/YYYY)

The University clinicians and counsellors will use information about you only to provide or assist in providing health care to you. The University very rarely may be required to disclose information to authorities in or outside the university, for example if:

1. There is concern that you may harm yourself or someone else or be unable to care for yourself;
2. You reveal apparent, suspected, or potential child abuse or neglect;
3. You report sexual abuse by a Regulated Health Care Professional;
4. Your physician or psychiatrist assesses you to have a medical condition that significantly impairs your ability to operate a motor vehicle.

Please sign below to indicate that you understand the conditions above.

X _____ **Date:** _____
Student Signature (MM/DD/YYYY)

UNIVERSITY OF TORONTO

HEALTH & WELLNESS CENTRE
CANCELLATION POLICIES

CHART#

Effective Date: September 14, 2015

STUDENT INFORMATION		
Last Name	**First Name**	**Student #**

Once an appointment is scheduled with Health and Wellness Centre ("HWC"), you will be expected to attend that appointment unless you give the required advance notice. More notice when possible would be appreciated as it helps us ensure we are assisting as many University of Toronto students as possible.

If you are unable to attend any scheduled appointment please call the Health and Wellness Centre at **(416) 978-8030** or go to **my.healthandwellness.utoronto.ca.** You can use your Web Access Account to cancel appointments scheduled 48 hours in advance.

a. Cancellation of a regular 15 minute medical appointment requires at least 4 hours' notice. Failure to give proper notification will result in a charge of $40 to you.
b. Cancellation of a 30 to 60 minute appointment or workshop requires at least 48 hours' notice. Failure to give proper notification will result in a charge of $60 to you***. Cancellation of such an appointment booked for a Monday must be cancelled by 4:30PM on Thursday the week before.***
c. Cancellation of a Colposcopy appointment with Dr. Graham requires 72 hours' notice. Failure to give proper notification will result in a charge of $75 to you.
d. If you have regularly scheduled appointments and do not arrive at one of these appointments, your subsequent appointment times may not be held for you in the following weeks.
e. A hold will be placed on your ROSI account for unpaid invoices from short notice cancellations or a no show visit. This may impact access to your transcripts.

Please sign below to indicate that you have read this agreement, understand it, and agree to the conditions outlined.

Signature: _____ Date: _____
(MM/DD/YYYY)

Thank you for your cooperation.

UNIVERSITY OF TORONTO

HEALTH & WELLNESS ENTRE

NEW PATIENT FORM

Date:_____ Chart No:_____

Please help us manage your ongoing medical care by filling out this form and handing it to your doctor at the beginning of your appointment.

1. Please list any **medications** you are currently taking with their doses.

_____
_____
_____

2. Are you **allergic** to any medications? If yes, please list them with the reaction.

_____
_____
_____

3. Please list any **ongoing** or **recurring medical problems** you have (e.g. asthma, diabetes, hepatitis, high blood pressure, depression, anxiety).

_____
_____

4. Please list any significant **past medical problems** you have had (e.g. surgery, trauma, hospitalization, depression, etc.)

_____
_____
_____

5. Have you had chicken pox? **Yes / No Don't Know**
☐ ☐ ☐

If NO, have you had the Varicella Vaccine? **Yes / No / Don't Know**
☐ ☐ ☐

6. Do you smoke? **Yes No**
☐ ☐

UHIP¤ Policy Number — 50150

Claim Authorization Form

Member name _____

Member ID _____

Telephone number _____

Health provider name _____

I certify that the statements in my claims are true and complete. I understand that the insurer may investigate my claims.

I authorize the insurer, its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims, and with the UHIP¤ plan administrator, for the purposes of claims management and intervention as appropriate on my behalf, under this insurance coverage with any person or organization who has relevant information about me including health professionals, government agencies, provincial health care plan, institutions, investigative agencies, insurers, and reinsurers. I understand that for audits and administrative reporting, the plan sponsor or administrator of this insurance coverage may have access to statistical and financial information without any personal identifiers.

I authorize the insurer and its medical consultants to exchange information about me with my health professional(s) for the purpose of claims management and intervention as appropriate on my behalf.

Insurance fraud is a crime. According to the Criminal Code of Canada, anyone who defrauds an insurance company can be found guilty of a criminal offence. Submission of false information in connection with this claim, therefore, may constitute a crime. In the event of insurance fraud, the insurer shall pursue all appropriate legal action, including criminal prosecution.

I hereby assign my benefits payable for claims under the UHIP¤ plan to the named health provider and authorize the insurer to remit payments directly to such provider.

I agree that a photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect until revoked by me.

Date: _____

Member signature _____

Sun Life Financial

PLACE LABEL HERE

CONSENT FORM FOR INTERNATIONAL PATIENTS

GOVERNING LAW

I hereby agree that the relationship and the resolution of any and all disputes arising there from between myself and the University of Toronto Health & Wellness Centre physicians and nurses shall be governed by and construed in accordance with the laws of the Province of Ontario.

JURISDICTION

I hereby acknowledge that the treatment will be performed in the Province of Ontario and that the Courts of the Province of Ontario shall have jurisdiction to entertain any complaint, demand, claim or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. I hereby agree that if I commence any such legal proceedings they will be only in the Province of Ontario, and hereby irrevocably submit to the exclusive jurisdiction of the Courts of the Province of Ontario.

PATIENT'S SIGNATURE: _____ WITNESS SIGNATURE: _____

PRINTED NAME: _____ PRINTED NAME: _____

DATE: _____ DATE: _____
(MM/DD/YYYY) (MM/DD/YYYY)