UNC STUDENT AFFAIRS

THE UNIVERSITY
of NORTH CAROLINA
at CHAPEL HILL

CAMPUS HEALTH SERVICES

JAMES A. TAYLOR BUILDING
320 EMERGENCY ROOM DRIVE
CAMPUS BOX 7470
CHAPEL HILL, NC 27599-7470

T 919.966.2281 (V/T)
TTY 711 (NC RELAY)
F 919.966.0361
campushealth.unc.edu

June 1, 2021

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

Ken Pittman MHA FACHE

CAMPUS HEALTH APPLICATION FOR SERVICES

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

*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 2021-2022 health fee of $42.51 is also required.

Applicant's Signature_____Date_____

Revised 5-20-21

Postdoctoral/Spouse Health History Form

Last Name First Name Middle/Maiden Date of Birth (mm/dd/yyyy) UNC PID#

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Self-Identify_____ Email: _____

Address: _____

☐ Postdoctoral ☐ Spouse Year Entering UNC: _____ Semester: ☐ Fall ☐ Spring Preferred Phone: ☐ Cell ☐ Home _____

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
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Unknown
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Unknown
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
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
ADD/ADHD			
Allergy Injections			
Asthma			
Other Respiratory Problems			
Autoimmune Disorders			
Blood Disorders (anemia, sickle cell)			
Bone, Joint or Mobility Issues			
Chickenpox			
Concussion or Traumatic Brain Injury			
Diabetes			

	Yes	No	Year
Disordered Eating			
Endocrine Issues			
Gastrointestinal Issues			
Gynecologic Issue			
Headaches/Migraines			
Hearing Problems			
Heart Issues or Pain/Pressure in Chest			
Hepatitis			
High Blood Pressure			
Kidney/Bladder Issues			

	Yes	No	Year
Mononucleosis			
Neurologic Disorders			
Psychiatric Disorders (Anxiety, Depression)			
Other Psychiatric Disorders			
Rheumatologic Disorders			
Substance/Alcohol Abuse			
Tumor or Cancer			
Vision Problems			
Other:			

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
Received counseling for mental health concerns			
Taken a prescribed medication for mental health concerns			
Been hospitalized for mental health concerns			
Seriously considered attempting suicide			

	No	Yes	Year
Purposefully injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)			
Received treatment for alcohol or drug use			
Experienced harassing, controlling and/or abusive behavior from another person			

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 judgment 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. Legally permitted disclosures may include reporting the purchase of pseudoephedrine or controlled substances and the disclosure of patient information to State and federal agencies with jurisdiction over health care disciplines when required by an on-going investigation. 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 or needs to obtain a prior authorization for a medication, treatment, or procedure, your records pertaining to that referral or prior authorization 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: https://campushealth.unc.edu/charges-insurance/insurance.

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. The purpose of any release of my information is to administrate the provision of health services. 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 age18:_____ 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

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
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong
China, Macao
Colombia
Comoros
Congo
Cote d'Ivoire
DPR of Korea
DR of Congo
Djibouti
Dominical Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal

Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland (AKA Eswatini)
Syrian Arab Republic
Taiwan
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Yemen
Zambia
Zimbabwe

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 as soon as you arrive on campus.

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.

Updated 2/2017, 4/19, 5/19,4/20, 5/21