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 2020-2021 health fee of $41.68 is also required.

Applicant's Signature____Date_________

Revised 4-27-20

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

UNC STUDENT AFFAIRS

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 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. 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 age18:__________________________Date: ____________________

campus HEALTH

UNC STUDENT AFFAIRS

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

http://campushealth.unc.edu

April 30, 2020

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
Executive Director for Campus Health Services

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UNC STUDENT AFFAIRS

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