Brandeis Health Center is an on campus service to assist you in meeting your goals for health and success while at Brandeis. Please read the following information regarding your required health documentation.

**INSURANCE REPORTING and ENROLLMENT**

DUE July 1, 2016 for Fall Admits  
DUE Dec. 1 for Mid-Year Admits

All full and three quarter time students must report adequate health insurance coverage to the school annually. The school offers a qualifying Student Health Insurance Plan (SHP) that meets federal, state, and visa insurance mandates. Brandeis Health Center recommends the plan to assure adequate health coverage in the area in which you are attending school. International students must enroll in the SHP plan annually. Information on the SHP and the required on-line enrollment or waiver form is available at [www.universityhealthplans.com/brandeis](http://www.universityhealthplans.com/brandeis). Call 1-800-437-6448 or email info@univhealthplans.com with questions or concerns about your insurance reporting.

**HEALTH RECORDS**

DUE July 22, 2016 for Fall Admissions  
DUE Dec. 15, 2016 for Mid-Year Admissions

The enclosed (8 page) health record is a confidential record to assist with treatment services at the Health Center and for assuring that we are meeting state public health regulations. The student must complete pages 1, 2, 3 and sign the enclosed general agreement while the remaining pages must be completed by your medical care provider. **Please call your provider’s office to schedule a physical examination, to assure your required immunizations are up to date, and to complete the tuberculosis screening as needed. Health records must be submitted via mail service (USPS, Fed Ex, DHL etc.) or by faxing a legible copy to our dedicated fax line at 781-736-3675.** We are unable to accept electronic health records at this time.

We do not routinely share the confidential information reported with any other services on campus. Your physical exam may be used to fulfill the varsity sport requirements if it was done within 6 months of arrival to campus. If you are reporting psychological or health concerns for which you will need to schedule follow up services on campus or if you have further questions please contact those services directly at:

- The Health Center: 781-736-3677  
- The Psychological Counseling Center: 781-736-3730  
- Student Financial Services: 781-736-4486  
- Disability Services: 781-736-3470  
- Department of Community Living: 781-736-5060
Information about BRANDEIS HEALTH CENTER

School Year Hours (Starting August 29, 2016):
Monday-Friday 9 a.m. – 6 p.m.   Closed for meetings Mondays 2-3
Telephone: (781) 736-3677       fax: (781) 736-3675
www.brandeis.edu/studentaffairs/health

ALL enrolled Brandeis students may utilize Brandeis Health Center services. Please stop by or call to schedule an appointment.
Health Center services include:

- Acute illness and injury care
- Coordinated care of chronic conditions,
- Immunizations and flu shots,
- Travel planning and preparation,
- Physical and work clearance exams
- Nutrition counseling,
- Sexual and reproductive health services,
- Lab collection and on-site testing,
- Prescription delivery service,
- Referral to local specialists.

Some things you can do to prepare for your health needs while away from home:

**Carry a copy of your insurance and prescription cards.** Review how your insurance works; when you will be charged copays (there are NO copays charged at the Health Center – they are paid by the school), coinsurance, and deductibles or need a referral. Massachusetts requires that you have reasonable coverage for emergency AND non-emergent care in the area of the school. For information on the Brandeis School Health Plan (SHP) visit www.universityhealthplans.com.

☐ **Review important components of your health history including** current medications, conditions that may reoccur, and allergies. Include this information in your Health Record. Review the available support resources on campus and how to access them. Please call us with any questions or concerns at 1-781-736-3677.

☐ **Make a personal first aid kit** complete with a thermometer, band-aids, sunscreen, insect repellant, and any self care, over the counter medications you may use such as acetaminophen and/or ibuprofen.

☐ If using **prescription medications or supplements** make sure you understand how to store them. We recommend you use a lock box to keep your prescriptions safe. Understand potential interactions with alcohol and other medications. Refills can be delivered to the Health Center - see our website (www.brandeis.edu/studentaffairs/health) for more information on pharmacy delivery services.

☐ Make sure your **immunizations are up to date and get your flu shot** annually (watch for our flu clinic notifications in your e-mail or like us on Facebook: Brandeis University Health Center).
PLEASE NOTE

Your completed health records are required before arrival to campus. Please make an appointment with a health care provider to complete your records. The Health Center can assist with completing vaccine series that have been initiated as needed. Additionally, you must report your health insurance or enroll in the School Health Plan. www.universityhealthplans.com. International students must enroll in the School Health Plan.

UNDERGRADUATE HEALTH RECORD

2016-2017

Brandeis University Health Center
Submit forms by mail or by faxing:
415 South Street MS 034
Waltham, MA 02454-9110
Telephone 1-781-736-3677
Fax: 1-781-736-3675
www.brandeis.edu/health

FOR BRANDEIS HEALTH SERVICES USE ONLY

ALLERGIES:
Date Received: ___________________
MMR: #1 ☐ MMR #2 ☐
Tdap: ☐
Hep B: #1 ☐ #2 ☐ #3 ☐
Meningococcal: ☐
Varicella: #1 ☐ #2 ☐ disease ☐
PPD risk: low ☐ high ☐
Results: neg ☐ pos ☐
CXR: ☐ INH: ☐
Physical Exam: ☐
General Agreement: ☐
Complete: ☐ Exemption: ☐

Your Contact Information:

Name: ____________________________ Gender__________ Date of Birth: ___________ Month __ Day __ Year

Last                                                             First

Primary Address: ________________________________________________

Street

City State Zip Code Country

Home Telephone: (____)_________________________ Cell Phone: (____)_________________________

Email Address: ________________________________________________ Semester entering Brandeis University: F_____ Sp _____

Parent/Guardian Contacts:

Parent Name: ____________________________ Parent Name: ____________________________

Parent Home Phone: (____)_________________________ Parent Home Phone: (____)_________________________

Parent Profession: ____________________________ Parent Profession: ____________________________

Parent Business Phone: (____)_________________________ Parent Business Phone: (____)_________________________

Parent Cell Phone: (____)_________________________ Parent Cell Phone: (____)_________________________

Alternate Emergency Contact:

Name: ____________________________ Relationship: ____________________________

Last                                                             First

Address: __________________________________________________________

Street City State Zip Country

Home Telephone: (____)_________________________ Business Telephone: (____)_________________________

Attach a photocopy of the front and back sides of your health insurance card.
☐ Check this box if you will be enrolling in the Brandeis School Health Plan.
Student’s Name: ___________________________ Date of Birth: ________________

**ALLERGIES:** Please specify, including medications, insect venom, food, etc., and include type of reaction.

Please note that allergy desensitization injections are not given at The Health Center.

**Current Medications:** Please list all medications that you are presently taking, including vitamins, herbals, non-prescription medications, and prescription medications including hormonal contraceptives.

**Personal History:** Check the box if you have had any of the following health issues:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Cause of Death</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of paired organ (eye, ear, kidney, testicles, ovaries)</td>
<td>Gastritis/GERD</td>
<td>Mononucleosis</td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td>Gynecological issue/ abnormal Pap</td>
<td>Neuromuscular disease</td>
</tr>
<tr>
<td>Alcohol/drug issues</td>
<td>Heart murmur/click</td>
<td>Overweight/obesity</td>
</tr>
<tr>
<td>Anemia /bleeding disorder</td>
<td>Heart disease/problem</td>
<td>Phlebitis/ deep vein clot</td>
</tr>
<tr>
<td>Appendectomy</td>
<td>Hepatitis</td>
<td>Pneumothorax</td>
</tr>
<tr>
<td>Asthma</td>
<td>High blood pressure</td>
<td>Seizure disorder</td>
</tr>
<tr>
<td>Blindness/visual impairment</td>
<td>High cholesterol</td>
<td>Sickle Cell Disease /trait</td>
</tr>
<tr>
<td>Blood clots</td>
<td>Impaired mobility/paralysis</td>
<td>Sleep disorder/ insomnia</td>
</tr>
<tr>
<td>Breast disease or lumps</td>
<td>Inflammatory bowel disease (colitis or Crohn’s)</td>
<td>Stroke</td>
</tr>
<tr>
<td>Cancer/malignancy</td>
<td>Irregular heart beat</td>
<td>Testicular problem</td>
</tr>
<tr>
<td>Cigarette smoking</td>
<td>Irregular menstrual cycle/no periods</td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Concussion/serious head injury</td>
<td>Kidney disease</td>
<td>UTIs (frequent/recurrent)</td>
</tr>
<tr>
<td>Deafness/hearing impairment</td>
<td>Kidney stones</td>
<td>Weight gain /loss (recent)</td>
</tr>
<tr>
<td>Depression</td>
<td>Learning disability</td>
<td>Other (please specify)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Liver disease/ jaundice</td>
<td></td>
</tr>
<tr>
<td>Eating disorder</td>
<td>Malaria</td>
<td></td>
</tr>
<tr>
<td>Emotional/mental illness</td>
<td>Meningitis</td>
<td></td>
</tr>
<tr>
<td>Fainting/loss of consciousness</td>
<td>Migraines/chronic headaches</td>
<td>No significant past medical history</td>
</tr>
</tbody>
</table>

Please give details of any significant health concerns (attach additional pages if necessary):

Please give details of any hospitalizations, major injuries, major illness, and operations:

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Age</th>
<th>State of Health</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Have any of your immediate relatives had any of the following: Yes</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Alcoholism / Drug Issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Blood Clots or Bleeding Disorder</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Cancer</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Heart Disease/High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kidney Disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mental Illness/Suicide (or Attempts)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Seizure Disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
</tr>
</tbody>
</table>
Brandeis University Health Center  
TUBERCULOSIS (TB) RISK QUESTIONNAIRE  
Must be completed by all students and returned with Health Report

<table>
<thead>
<tr>
<th>Student’s Name: _________________________________________________</th>
<th>Date of Birth: ____________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Have you ever had a positive tuberculosis skin test? (If yes, go to C on next page)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Were you born on the continent of Africa, Asia, South America, or in Central America, Mexico, Eastern Europe, the Caribbean, or the Middle East?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In what country were you born? _______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>In the past 5 years, have you lived or traveled on the continent of Africa, Asia, South America, or in Central America, Mexico, Eastern Europe, the Caribbean, or the Middle East for more than one month?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>In the last 2 years have you lived with or spent time with someone who has been sick with TB?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Do you have (or have you had) any of these medical conditions: Diabetes, Kidney disease, HIV infection, Colitis, Cancer, Stomach or intestine surgery, Rheumatoid arthritis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Are you taking any medications that your doctor said could weaken your immune system or increase risk for infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>In the past 1 year, have you injected any drugs that your doctor did not prescribe?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Have you ever lived or worked in a prison, jail, homeless shelter or long term care facility such as a nursing home, substance abuse treatment or rehabilitation facility?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom Screening—Right now, do you have any of these symptoms?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coughing for more than 2-3 weeks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing up blood?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss of more than 10 pounds for no known reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever of 100 degrees F (38 degrees Celsius) for over 2 weeks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unusual or heavy sweating at night?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unusual weakness or extreme fatigue?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answer “yes” to any of the questions above then you must have a medically documented Tuberculin skin test or IGRA blood test to screen for exposure to Tuberculosis.  
If you answered “No” to All of the above questions then proceed to having your health care provider complete your immunization report.
Brandeis University Health Center
Medical Evaluation for Latent Tuberculosis Infection (LTBI)
(To be completed and signed by a licensed medical provider)

Student’s Name: ___________________________ Date of Birth: ____________

A. **TUBERCULIN SKIN TEST** (Mantoux)
Test must be read by a health care provider 48 – 72 hours after administration. If no induration, indicate “0mm”. Results of multiple puncture tests, such as Tine or Mono-Vac are NOT accepted.

Date administered: ____/____/____ Lot: ______________________ Exp date: ______________________

Date test read: ____/____/____ Result: ____ mm of induration (sign bottom of page)

OR

B. **Interferon Gamma Release Assay (IGRA)** (Copy of Lab Report REQUIRED-Please attach)

Date obtained: ____/____/____ Specify Method: QFT-GIT T-Spot other ______

Result: ☐ Negative ☐ Positive ☐ Indeterminate ☐ Borderline (T-Spot only)

<table>
<thead>
<tr>
<th>Interpretation of Tuberculin Skin Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Factor</td>
</tr>
<tr>
<td>Close contact with a case of tuberculosis</td>
</tr>
<tr>
<td>Born in a country that has a high rate of tuberculosis</td>
</tr>
<tr>
<td>Traveled or lived for a month or more in a country that has a high rate of Tuberculosis</td>
</tr>
<tr>
<td>No risk factors (test not recommended)</td>
</tr>
</tbody>
</table>

C. If Tuberculin Skin Test or IGRA is **POSITIVE**, now, or by history, the following are **REQUIRED**:

1. Date of positive PPD or IGRA: ____/____/____ Results ______ mm.

2. Chest X-ray: **Copy of X-ray Report REQUIRED.** Date of X-ray: ____/____/____
   - ☐ Normal ☐ Abnormal __________________________ (Describe)

3. Clinical Evaluation:
   - ☐ Normal ☐ Abnormal __________________________ (Describe)

4. Treatment:
   - ☐ No ☐ Yes ________________________________ (Drug, dose, frequency and dates)

HEALTHCARE PROVIDER SIGNATURE (REQUIRED): ________________________________

Date: ____________ Tel: (______)________________________ Fax: (______)________________________
IMMUNIZATION RECORD

In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15c, and Department of Public Health Regulations 105 CMR 220, Brandeis University requires verification of immunity for all mandated immunizations.

Student’s Name ____________________________________________________ Date of Birth _______ / _______ / _______

Last Name ___________________________ First Name ___________________ M.I. ___________________

I. MANDATORY IMMUNIZATIONS

Please record doses given only, NOT anticipated dates of next doses.

ALL DOCUMENTATION MUST BE VERIFIED (by a non parent) LICENSED HEALTH CARE PROVIDER

MMR (MEASLES, MUMPS, RUBELLA) 2 doses required

☐ Dose 1 Immunized at or after 12 months of age

☐ Dose 2 Given at least one month after Dose 1

If unable to document Measles, Mumps and/or Rubella immunization dates, you must have antibody titers. This is a blood test to prove you are immune. A copy of the lab report with the value in English is required.

TETANUS, DIPHTHERIA and ACELLULAR PERTUSSIS (Tdap)

Required within past ten years

Date: _______ / _______ / _______

HEPATITIS B VACCINE

Dose 1 _______ / _______ / _______ Dose 2 _______ / _______ / _______ Dose 3 _______ / _______ / _______

If unable to document Hepatitis B immunization dates, you must have an antibody titer (HBsAB).

A copy of the lab report with the value in English is required.

MENINGOCOCCAL (quadrivalent) VACCINE

(administered after the age of 16 and within the last 5 years)

Date: _______ / _______ / _______

If unable to document Meninigooccal B immunization dates, you must have antibody titers (MenB).

A copy of the lab report with the value in English is required.

VARICELLA VACCINE

Dose 1 _______ / _______ / _______ Dose 2 _______ / _______ / _______ or Date of disease _______ / _______ / _______

PLEASE NOTE: History of disease must be documented by a health care provider. If unable to document Varicella (chicken pox) infection or immunization dates, you must have antibody titers. A copy of the lab report with the value in English is required.

II. RECOMMENDED (NOT REQUIRED)

Hepatitis A Vaccine

Dose 1 _______ / _______ / _______ Dose 2 _______ / _______ / _______ Dose 3 _______ / _______ / _______

HPV Vaccine

Dose 1 _______ / _______ / _______ Dose 2 _______ / _______ / _______ Dose 3 _______ / _______ / _______ Dose 4 _______ / _______ / _______

Meningococcal B

Dose 1 _______ / _______ / _______ Dose 2 _______ / _______ / _______ Dose 3 _______ / _______ / _______

Polio Vaccine

Dose 1 _______ / _______ / _______ Dose 2 _______ / _______ / _______ Dose 3 _______ / _______ / _______ Dose 4 _______ / _______ / _______

HEALTH PROVIDER VERIFICATION:

Name ______________________________________________________ MD, NP, PA, DO Date __________________________

Signature________________________________________________ Telephone __________________________

Page 5 of 8
**Brandeis University Health Center**  
**Physical Examination Form**

Must be completed within the past year (six months for a varsity athlete) by a non-parent provider. If you plan to participate in athletics this physical exam should serve as a pre-participation sports physical. The Athletic Trainer may have access to the physical examination report of students who elect to participate in varsity athletics.

**Student’s Name:** __________________________  
**Date of Exam:** ______________  
**Date of Birth:** ______________

**Height** ________ **Weight** ________ **BP** ________ **Pulse** ________ **Vision test:** OD______ OS______ OU______

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>NORMAL</th>
<th>DESCRIBE ABNORMALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs/Chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen (rectal prn)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genito-urinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic (if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculo-skeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If any blood tests are done, please include a copy of the results.

**CURRENT AND CHRONIC PROBLEMS:** If the student is under care for a chronic condition or serious illness, please provide additional clinical reports to assist us in providing continuity of care.

____________________________________________________________________________________________________

**CURRENT MEDICATIONS** (include Vitamins, Over the Counter Medication, Contraceptives, Inhalers, and Epi-Pens):

____________________________________________________________________________________________________

**ALLERGIES to Medications:** __________________________  
**Type of Reaction:** __________________________

**Allergies to Other Things:** __________________________  
**Type of Reaction:** __________________________

Has an Epi-pen been prescribed? ________________

Recommendations for physical activity and/or sports participation:  
☐ unlimited  
☐ limited (specify)

____________________________________________________________________________________________________

**Health Care Provider (please print)_____________________________  
Date__________________**

**Address______________________________**

**Phone (____)_________________  
FAX (____)________________**

**Provider’s Signature:______________________________**

Mail completed form to:  
Brandeis University  
Health Center  
415 South Street MS 034  
Waltham, MA 02454-9110  
Telephone (781) 736-3677  
Fax: (781)-736-3675
GENERAL AGREEMENT FORM (Page 1)

General Information:
I request care from Brandeis University Health Center for routine or intensive treatment of my medical/health conditions while enrolled as a student at Brandeis University. This care may include history taking, assessment, examinations, ordering of diagnostic medical tests or imaging, treatments, education, and recommendations for care including specialty or emergent services as needed. I agree to this treatment and care.

Use and Disclosure of Medical Information and Permission to Communicate with your Primary Care Physician, Other Community Care Providers, and/or Mental Health Providers:
Brandeis Health Center may share with others and request from others information to facilitate healthcare operations as well as for payment purposes, in accordance with the law.

- I agree to the sharing of my medical information for treatment, healthcare operations and payment purposes.
- I understand that these communications may include information about my medical treatment and mental health or substance abuse treatment. The information shared is only what is necessary to facilitate insurance claims and/or to coordinate my health care.
- I give my permission to communicate information about me either as an inpatient or an outpatient, as described above.
- I have the right to take back my consent or state limitations or restrictions on how my medical information may be used by submitting a statement in writing to Brandeis Health Center. This will be posted in my medical record and enacted except when my consent has already been acted upon, in the event of concerns about my imminent harm or harm to others, or legally mandated disclosures.

Insurance and Payment Information:
Brandeis University receives payments for patient care from insurance companies.

- I agree to let my Brandeis Health Center medical providers or the companies billing on their behalf, submit claims and treatment information to my health insurance program.
- I agree to have my insurance program make payments directly to Brandeis University or its billing representative.
- Brandeis University pays the copays for eligible students accessing Brandeis Health Center out of collected student fees.
- I understand that services provided from off campus providers such as labs, imaging services, pharmacies, durable medical equipment, and off-campus providers will be billed to my listed insurance(s) plans by those providers and I will be personally responsible for all uncovered charges.
- I understand that Brandeis University is not responsible for charges not covered according to my insurance plan.

Special Note about Mental Health Benefits
- I understand that if I am using my health insurance benefits to pay for mental health treatment, and/or substance abuse treatment, my insurance program may need some information from my clinician(s).
- The information which insurance companies need for initial sessions of outpatient treatment is limited in its scope (i.e. diagnosis, type of treatment). However, if my outpatient treatment is to go beyond those initial sessions authorized by my insurance company, then additional information will need to be given to my insurer. If I am going to receive mental healthcare as an outpatient, I understand that my insurance company may have limits on the number of visits for which it agrees to pay. It is my responsibility to stay informed of my plan’s mental health benefits.
- If I am going to receive mental health treatment as an inpatient, my insurer may request information from my clinicians about my hospitalization. This additional information allows my insurer to determine if the treatment is medically necessary and if payment for treatment will be authorized.
- I understand that my medical and mental health conditions are NOT automatically shared between the on campus Brandeis Counseling Center and Brandeis Health Center but may be shared in the event of needed collaborative management of my heath needs.
GENERAL AGREEMENT FORM (Page 2)

The Healthcare Team: I understand that treatment and care at Brandeis Health Center will be provided by a team of collaborative healthcare professionals with supervision of prescriptive practice and 24 hour consultation back up provided by a Medical Doctor.

- I understand that services at Brandeis Health Center are provided by doctors, nurse practitioners, nurses, dietician/nutritionists, medical assistants and reception staff.

Brandeis Health Center may have precepting clinicians working under the supervision of its clinical staff. I understand I will be made aware if a health care provider in training will be participating in my care and can refuse that participation at any time.

<table>
<thead>
<tr>
<th>A. General Information: I have read this form and I understand what it says. All of my questions have been answered in a language that I understand. I agree with the information on this form.</th>
</tr>
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<td>X ____________________________ OR</td>
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<tr>
<td>Patient’s Signature       Print Name</td>
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<tr>
<td>____________________________ and ____________________________</td>
</tr>
<tr>
<td>Signature of Person authorized to sign for patient Print Name Relationship to Patient</td>
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<tr>
<td>Date: <strong><strong><strong><strong><strong>/</strong></strong></strong></strong></strong>/__________</td>
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<th>B. Privacy Notice: I have received copies of the Brandeis Health Center “Notice of Privacy Practices” and “Your Rights and Responsibilities as a Patient”, available online at <a href="#">Brandeis Health Center’s web page</a>. Brandeis University has the right to change privacy practices. Any changes will be effective for medical information Brandeis Health Center already has about me as well as information Brandeis Health Center receives in the future. I am aware that I may request printed copies of “Notice of Privacy Practices” and “Your Rights and Responsibilities as a Patient” from the Brandeis Health Center.</th>
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