Vinson Health Center

Patient Rights

I have read and/ or been offered a copy of my "Patient Rights"

(Initial)_____

Notice of Privacy Practices

I have read and/ or been offered a copy of the "Notice of Privacy Practices" (HIPPA)

(Initial) _____

Consent to Use of Telemedicine

I hereby authorize Dr. Keith Williamson to use telemedicine in the course of my diagnosis and treatment.

(Initial)_____

Advanced Directive

Do you have an Advanced Directive (**Living Will**)?

Y____N____

If YES, please provide a copy for our records.

Financial Responsibility

I understand I am responsible for fees accrued during visits at Vinson Health center

(Initial) _____

For All Students:
By signing below, I verify that the information provided on this form is correct.

_____ _____

Date Student Signature

4/2020