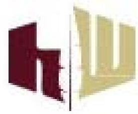


THE FLORIDA STATE UNIVERSITY

UNIVERSITY HEALTH SERVICES

HEALTH & WELLNESS CENTER

University Health Services
Florida State University
960 Learning Way
Tallahassee, FL 32306-4178
(850) 644-3608
Fax: (850) 644-8958

Healthcare Compliance Information

Florida State University's University Health Services (UHS) is staffed by physicians, nurse practitioners, registered nurses, nutritionists, health educators, and various support personnel to serve your healthcare and health education needs. It is funded in part by a portion of the fee you pay to FSU. *Website:* www.uhs.fsu.edu

Services Provided

UHS is a fully accredited primary care center. A team of dedicated professionals provides a variety of wellness, minor illness, injury and urgent medical care and outreach programs through the general medical clinics, a women's clinic, a nutrition clinic, a physical therapy clinic, a psychiatric clinic, a radiology clinic, an allergy clinic, a travel clinic, a triage clinic and a vibrant health promotion department. Quest Labs is the in-house full service laboratory; pickup service is available for students whose insurance requires the use of Lab Corps.

Payment for Services

UHS accepts cash, checks, VISA, MC, FSUCard, HSA cards and insurance as payment for services. You may also defer charges to your Student Financial Services (SFS) account; however, doing this will result in a registration HOLD until paid in full. UHS is an in-network provider for Aetna PPO and selected HMO health plans, most BCBS PPO plans, Humana and United Health Care PPO plans. Claims to other insurance carriers are billed as "out-of-network." Any amount not covered by your insurance plan will be placed on your SFS account. It is the student's responsibility to know what his/her individual plan covers. Some HMO insurance plans require that you have a referral or pre-authorization to be seen at UHS. Medicaid and Medicare cannot be used to pay for services at UHS but can be used to meet the insurance requirement to be able to register for classes.

Confidentiality of Records

Medical records are strictly confidential. For patients age 18 and older written consent by the patient is required before records can be released. Authorization for release of medical records must be done on a per-visit or per condition basis and is valid until revoked by the student. **There is no blanket release for students to sign.** Parents or legal guardians of students under 18 have the legal right to review medical records for their children except for issues dealing with sexual health.

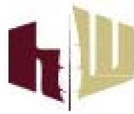
Health Compliance Packet:

Form 1 – Health History Form - SUBMIT
Form 2 – Student Immunization Record – SUBMIT
Form 3 – Health Center Patient Disclosure Authorization - SUBMIT
Form 4 – Privacy Policy – DO NOT SUBMIT
Form 5 – Vaccine Information Sheet – DO NOT SUBMIT

Effective July 1, 2011. All other editions of these forms are obsolete.

Please Submit Form 1, Form 2, and Form 3 to
University Health Services
c/o The Health Center Compliance Office
960 Learning Way, Tallahassee, Fl 32306-4178
Ph. 850-644-3608./ Fax 850-644-8958.
Or Use the FSU drop box at http://dropbox.fsu.edu

See attachment for instructions on how to submit forms electronically.
Processing the health compliance forms can take up to five days.
It is the responsibility of the student **to verify clearance at**
https://admissions.fsu.edu/StatusCheck/ .



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Student Health History Form (Form 1)

- **This is a one-time requirement for enrollment.** You will be asked to update this record whenever you receive services at University Health Services (UHS).
- **Section A:** Complete entirely. Enter your full name, date of birth, FSUSN or FSUID, complete mailing address, home and mobile telephone numbers and an email that you actually will read.
- **Section B:** Initial the sections for Student Observers and Notice of Privacy Policy (provided for you at Form 4) to acknowledge understanding and receipt of these two policies.
- SIGN the CONSENT to TREAT to receive services at University Health Services. For students **under age 18,** a parent or legal guardian's signature is required on this form (Form 1) BEFORE any treatment can be rendered to the student at University Health Services.
- Failure to initial and sign as directed will create a block to the student's ability to register for classes. The initials and signature cannot be electronically generated.

Student Immunization Record (Form 2)

- **This is a one-time requirement.**
- **This form must be completed by AUTHORIZED PERSONNEL ONLY**. To be considered valid, this form and any additional records submitted to the Health Compliance Office must include:
  - The **signature** of the authorizing person (a school administrator or medical provider can be an authorized signer of this document). ***Parents and Students are not authorized to enter immunization dates.***
  - an **office stamp** showing the complete office address, telephone and **fax number**,
  - the student's name and date of birth
  - the cover of any attached shot records that identify the attached record with the student. Records attached to this form must also be signed and have an office stamp or office mailing address on them.
- **We reserve the right to interpret the validity of all documents submitted.**
- Any corrections to the entries on Form 2 MUST BE COMPLETELY REAUTHORIZED with the authorized signer's initials and the date the correction is made.
- All documents must be dated, signed and legible to be processed. The student signature in Section B is required. **The ability to register for classes will be blocked until the student signature is obtained.**
- **Immunization requirements:**
  - Students born **BEFORE 1/1/57** must complete the Immunization Record Form and may decline the meningococcal meningitis and hepatitis B vaccines via the waiver in the spaces provided. If they wish to receive the meningococcal meningitis and/or hepatitis B vaccines, that is permitted. Sign the form and submit it.
  - Students born **on or after** 1/1/57 must provide proof of two MMR (measles, mumps, and rubella) immunizations.
    - **The first MMR must have been given on or after 1/1/68 and on or after the first birthday.**
    - The second MMR immunization must have been given 28 days or more **after** the first MMR.
    - **Positive IgG titers** for measles (Rubeola), German measles (Rubella) and Mumps antibodies may be submitted in lieu of proof of two MMR. **Copies of the actual lab results showing the positive titers** must be provided to the Health Compliance Office **before** the student will be able to register for classes.
  - All students must show proof of vaccination for meningococcal meningitis and hepatitis B. If, after reading the Vaccine Information Page, a student wishes to decline either one or both of these vaccines, the waiver(s) in Section B of Form 2 must be initialed. Electronically generated initials are not acceptable. A titer proving immunity to hepatitis B may be submitted in lieu of proof of the hepatitis B series. There is no titer for meningococcal meningitis at this time.
- **Special Notes:**
  - A permanent or temporary medical exemption due to a health issue that precludes receiving the MMR vaccine must accompany the completed healthcare compliance packet. The medical exemption must be submitted on your provider's letterhead and signed and dated by your provider. Temporary exemptions must also include an expected end date for the exemption. Forms 1, 2 and 3 must be submitted.
  - Understand that in the event that a vaccine preventable outbreak occurs on the Florida State University Campus, and:
    - you are unable to show proof of adequate immunization via previous medical records, or
    - you are unable to show proof of immunity via a positive titer (a blood test showing immunity to the infection), THEN
    - you may be excluded from attending classes or other activities on the Florida State University campus for the duration of the outbreak, which can be up to 21 days following diagnosis of the last case.
  - Understand also that you
    - agree that you shall be solely responsible for any costs associated with exclusion from classes or university activities and
    - are aware that should such exclusions affect your grades and attendance records, you will be ineligible to apply for either a medical course drop or a medical withdrawal due to a situation or situations resulting from a vaccine preventable incident.

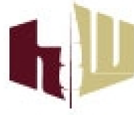
- Clearance for registration for classes will not be given without the **patient AND provider signature.**

Patient Disclosure Authorization (Form 3)

- **This is a one-time requirement for enrollment.** You will be asked to update this record whenever you receive services at University Health Services (UHS).
- Complete, sign, date and return this form with Forms 1 & 2.

Insurance Requirements

This is an annual requirement. Every full time student new to Florida State University must provide proof of adequate health insurance coverage **before** the registration block will be removed. International students studying at FSU on a J-1 or F-1 visa must show proof of health insurance regardless of credit hour load. Purchase or waiver can only be done on line at the student insurance web site: www.studentinsurance.fsu.edu. Before logging in to complete the waiver or purchase, review the private insurance requirements and plan information at the home page. Requests to change or cancel the purchase of the school-sponsored insurance must be submitted in writing to healthcompliance@admin.fsu.edu no later than 30 days following selection of health insurance on line. To begin the waiver or purchase process click on the flashing red and black link above the backpack.



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Health Compliance Checklist

1. Healthcare Compliance Packet

- Find it at www.healthcenter.fsu.edu - It is the first document on the FORMS page. Complete and submit ONLY Forms 1, 2 and 3. All other pages are for your information and should not be sent to the Compliance Office.
- Fax Forms 1, 2 and 3 to 850-644-8958, **OR**
- Mail them to Health Compliance Office, 960 Learning Way, Tallahassee, FL 32306-4178, **OR**
- E-mail them to the electronic drop box. Instructions are in the packet. **OR**
- Bring them to room 1005, Health and Wellness Center. Forms submitted at Orientation may take up to 5 days to process.
- Every student enrolling in FSU must submit these forms **one time**.
- **REMEMBER TO SIGN FORMS 1, 2 and 3 where it says: Student Signature! If you are not yet 18, your parent or guardian must also sign Form 1. If your parent signs the forms where you are supposed to sign, your forms will not be cleared.**

2. Proof of Immunizations

- It is Form 2 in the packet.
- Two MMRs (measles, mumps, rubella) combined immunizations must have been given on or **AFTER** the first birthday and at least 28 days apart. Single shots are **only** acceptable if all three were given on the **same** day. IgG titers showing positive immunity to measles, mumps and rubella may be submitted in lieu of proof of the two MMR immunizations. The lab slips showing the test results must be submitted. Negative or equivocal results are not acceptable.
- Meningococcal meningitis immunization proof **OR** waiver.
- Hepatitis B immunization proof **OR** waiver **OR** proof of positive immunity via a titer.
- Must be signed and dated by medical personnel **OR** custodian of records. The office fax number is required. The signer's printed name is also required.
- Any corrections to immunization dates must be initialed and dated by the person authorizing the records.
- Every student enrolling in FSU must submit this form **one time**.
- Registration will be blocked until this requirement is met.

3. Proof of Health Insurance

A. *International students* are those students studying at FSU on a J-1 or F-1 visa.

- They are required to show proof of health insurance regardless of their credit hour load.
- Accompanying dependents must also be covered by health insurance.
- International students must either enroll in the school sponsored health insurance plan or waive enrollment in the school sponsored plan by showing proof of other comparable insurance.

B. Domestic students are those students who are not studying at FSU on a J-1 or F-1 visa.

- Full time students new to the university (undergrads taking at least 12 hours and grads taking at least 9 hours, newly admitted or re-admitted) must either enroll in the school sponsored health insurance plan or waive enrollment in the school sponsored plan by showing proof of other comparable insurance. A credit hour load of 6 credit hours during summer session is considered full time for both undergraduate and graduate students.

- If you are enrolling as a part-time student, call the health compliance office at 850-644-3608 to have your insurance waiver cleared with a credit hour underload. This must be done each semester and cannot be done on line.
- Students enrolled in the summer 2007 term or earlier who are still in the same program are grandfathered and are not required to show proof of health insurance.

C. How to take care of the compliance requirement:

- Go to **www.healthcenter.fsu.edu**. Click on the Support Services bar. Select Insurance, Immunizations and Compliance. Follow the prompts.

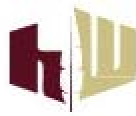
  OR
- Go directly to **www.studentinsurance.fsu.edu** **.**
- Click on the flashing black and red link: **Waive/Purchase Insurance Click Here.** It is above the black backpack surrounded by students.
- Log in.

  If you do not have your FSUID you can get it here by following the prompts.
- To ***purchase*** the school sponsored health insurance, select the **Purchase FSU Insurance** button.
  1. If you select the Pay Now button you will have to supply a credit card number and will be charged the premium immediately.
  2. If you do not select the Pay Now button the charges will go on your account to be paid by your financial aid when it is disbursed.
- If you purchase the school sponsored health insurance, make certain to update your local mailing address at Secure Apps of your blackboard account. That is the address the insurance carrier will use to send you your new insurance card. It must be USPS approved. If you have a U Box, enter it in your local mailing address as PO Box. The post office does not deliver to residence hall street addresses. If you live in an apartment, put the street address first and the apartment number second.
- **The student sponsored insurance does not cover participation in collegiate athletics. Check with Nick Pappas at 850-645-2700 for insurance options. It does cover FSU Cheerleader and Golden Girl members as sports club participants.**

  OR
- To complete the ***hard waiver*** and enter your private insurance policy information, select the **Insurance Waiver** button.
- Follow the prompts. Make sure to select the term and year that will show continuous coverage for you even if you will not be attending summer sessions.
- This requirement must be met **once annually**.
- **Remember, if you are not** attending as **a full-time student,** contact the Compliance Office for a Credit Hour Underload to clear your insurance requirement.

4. To Resolve Compliance Issues for either insurance or immunizations:

- If you have submitted your information and still are listed as non-compliant, call 850-644-3608 or send an e-mail to healthcompliance@admin.fsu.edu.



THE FLORIDA STATE UNIVERSITY
UNIVERSITY HEALTH SERVICES
HEALTH & WELLNESS CENTER

REQUIRED

STUDENT ADMISSIONS HEALTH HISTORY (Form 1)

YOU WILL NOT BE CLEARED TO REGISTER AT FSU WITHOUT THIS COMPLETED FORM (ALL PAGES)
AND ADEQUATE PROOF OF IMMUNIZATIONS ON FILE

MAIL or FAX ALL COMPLETED PAGES TO:
University Health Services
Health Compliance Office
960 Learning Way
TALLAHASSEE, FLORIDA 32306-4178
Fax: 850.644.8958

TO VERIFY CLEARANCE CHECK
https://admissions.fsu.edu/StatusCheck/
THIS FORM REQUIRES FIVE DAYS FOR PROCESSING

Information:
healthcenter.fsu.edu
Insurance: 850.644.4250
Immunizations:850.644.3608

Or Electronically submit using FSU drop box (see attachments within packet for instructions for submitting **Personal Health Information in a Secure Format)**

SECTION A -. PRINT TWO COPIES OF THIS FORM. SUBMIT ONE; KEEP THE OTHER FOR YOUR RECORDS.

PLEASE PRINT LEGIBLY (ILLEGIBLE FORMS WILL NOT BE PROCESSED)

NAME Last	First	Mi	DOB	FSU SN or FSU ID	Sex	Race
			___/___/___		F ...M	

Address	**City**	**State**	**Zip**

Home Phone:( )	**Cell Phone:( )**

Email Address:

Primary Care Physician:	**Address**	**Phone/Fax**

SECTION B–

Please list any relevant personal medical history: ______________________________

Please list any relevant family medical history: ______________________________

Do you have any allergies (to incl. medications): No Yes Please list if answered yes: ______________________________

SECTION C -

PLEASE READ AND INITIAL EACH SECTION BELOW

Student Observers

________I understand and acknowledge, by signing this document, that FSU Student Health and Wellness Center, as part of Florida State University, may have students from healthcare majors (i.e. College of Nursing, College of Medicine, College of Human Sciences) as observers during the course of my visit at UHS. I further understand that the UHS staff members will inform me when a student is observing my care. I give UHS permission to allow a student observer and I understand that I may at any time, decline to have a student observer during the course of my care at UHS.

Notice of Privacy Policy

________I acknowledge, by my signature below that I have received a copy of the FSU Student Health and Wellness Center Notice of Privacy Practices, included in this packet as Form 4, as required by Federal Regulations.

Consent to Treat

I authorize FSU Student Health and Wellness Center, its agents (ie College of Medicine, College of Nursing, First Responder Unit) and employees, to provide and perform such care, procedures, tests, and other services as are considered advisable by my clinician for my health and well being. I acknowledge that no guarantees have been made to me as to the effect of such examinations, procedures, and treatment of any condition.

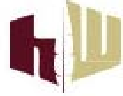
Student Signature ______________________________ **Date:** ____________________

REQUIRED AUTHORIZATION FOR CARE OF STUDENTS UNDER AGE 18: I CONCUR WITH THE ABOVE AND AUTHORIZE, AT THE DISCRETION OF HEALTH CENTER PERSONNEL, MEDICAL AND SURGICAL CARE INCLUDING EXAMINATIONS, TREATMENTS, IMMUNIZATIONS AND THE LIKE FOR MY SON/DAUGHTER. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable effort will be made to contact me but the failure to make contact will not prevent emergency treatment if necessary to help preserve life or health.

Parent / Guardian signature ______________________________ Date: ____________________

Student Name (Printed) ____ ________________ ______________

Last First MI FSU SN or FSU ID Date of Birth



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PART A – To be completed by Clinician/Records Custodian

REQUIRED

BOTH IMMUNIZATIONS MUST BE COMBINED MMRs. SINGLE SHOTS ACCEPTED ONLY IF ADMINISTERED ON THE SAME DATE.

MMR	Dose 1____/___/____ Month Day Year	Dose 2____/___/____ Month Day Year	
Meningococcal meningitis Vaccine If not provided, student must sign required waiver below.	Dose 1____/___/____ Month Day Year	Dose 2____/___/____ Month Day Year	
Hepatitis B If not provided, student must sign required waiver below.	Dose 1____/___/____ Month Day Year	Dose 2____/___/____ Month Day Year	Dose 3____/___/____ Month Day Year

RECOMMENDED

Polio	Dose 1____/___/____ Month Day Year	**Td (most recent booster)**	____/___/____ Month Day Year
TB skin test (PPD) **Mm ___ Pos ____ Neg ____** **If positive, provide documentation of treatment type and dates.**	____/___/____ Month Day Year	**Tdap (most recent booster)**	____/___/____ Month Day Year
Chicken Pox (varicella) Or date of disease: ____/___/____ Month Day Year	Dose 1____/___/____ Month Day Year Dose 2____/___/____ Month Day Year Titer ____/___/____ Month Day Year	**Gardasil**	Dose 1____/___/____ Month Day Year Dose 2____/___/____ Month Day Year Dose 3 ____/___/____ Month Day Year
Hepatitis A	Dose 1____/___/____ Month Day Year Dose 2____/___/____ Month Day Year	**Pneumococcal Vaccine** **(as indicated)**	____/___/____ Month Day Year

Attach additional physician comments regarding any history of prior vaccine allergic reactions, medical contraindications, etc:

AUTHORIZED CLINICIAN SIGNATURE: My signature verifies, as of this date, all entries documented. The form must be signed by the person who entered the information.

______________________ ______________________ __________ ______________________________

TYPED OR PRINTED NAME AUTHORIZED SIGNATURE DATE OFFICE STAMP WITH OFFICE ADDRESS & fax #

Immunizations given after the form has been signed must be separately documented on a separate sheet of paper, including authorized signature and office stamp with office address and fax. Use of a prescription pad is sufficient.

Part B - Must Be Completed By Student

STUDENT SIGNATURE REQUIRED REGARDLESS OF AGE. I HAVE READ AND UNDERSTAND THE IMMUNIZATION REQUIREMENTS ON THIS FORM. This form has been truthfully completed to the best of my knowledge and I freely consent to this form being used for my treatment at University Health Services and for my registration here or at any other university.

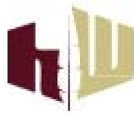
Signature____Today's Date_____________________

Meningococcal meningitis and Hepatitis B – Waiver must be completed **only** if dates of vaccines are not provided above.

I have received the required information regarding the risks of acquiring meningococcal meningitis and Hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations. I understand that declining these vaccines now does not mean I may not receive them in the future.

________I decline receiving the meningococcal meningitis vaccine. ________I decline receiving the hepatitis B vaccine

Initials Initial



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Fax: (850) 644-8958

Student Name (Printed) ____ ________________ __________
Last First MI FSU SN Date of Birth

Patient Disclosure Authorization:

Emergency Contact Name: ______________________________ Relationship to Patient: ______________________

Address:____Phone:(_________)______________________________

Do you want your treatment at University Health Services discussed with this person? Yes ☐ No ☐

The staff members of University Health Services consider all patient information confidential. Please list all individuals with whom we may discuss your medical condition, test results, and/or treatment plan. **This does not include Psychiatry.**

YOU MAY DISCUSS MY TREATMENT AT UNIVERSITY HEALTH SERVICES WITH:

Note: Accepted relationships include immediate family members such as, mother, father, spouse, and children. The Health Center will not honor disclosure for discussion of medical conditions, test results, and/or treatment plan to departments on campus or relationships other than those stated without proper medical release forms on file.

1.____Relationship ______________________________________

2.____Relationship ______________________________________

3.____Relationship ______________________________________

I understand that I have a right to revoke this authorization at any time except in the case that action has already been taken. I understand that if I revoke this authorization, I must do so in writing by completing a new Patient Disclosure Authorization Form. Unless otherwise revoked, this authorization will remain on file in my electronic record.

YOUR SIGNATURE BELOW ACKNOWLEDGES THE FOLLOWING

1. I understand and acknowledge by signing this document that I give University Health Services permission to file a claim to my health insurance carrier for the purpose of payment for services I have received at UHS. I further understand and agree that UHS may not be a contracted provider with my individual health insurance plan and that I may be responsible for any unpaid balance, or services not covered by my insurance plan. I understand that it is my responsibility to know what coverage I have under my individual plan. I give UHS permission to place these unpaid balances on my account with Student Financial Services. I am aware that any unpaid balance on my account with Student Financial Services will generate a “hold” being placed on my registration and that I may be assessed service fees on balances not paid by the due date assigned by Student Financial Services.

2. I understand I have a right to revoke this authorization at any time, except for cases where information has already been disclosed to those listed above. I understand that if I revoke this authorization, I must do so in writing by completing a new Patient Disclosure Authorization Form. Unless otherwise revoked this authorization will remain on file in my electronic health record.

Student Signature: ____Date:___________________________________