

CONSENT TO TREAT FORM

Student Information

Name: _____ Date of birth: _____
 First Middle Last MM-DD-YYYY

Student ID: _____ Phone Number: _____

Emergency Contact

Name: _____ Phone Number: _____
 First Middle Last

Consent to Medical Treatment

I voluntarily consent to receive medical care and treatment as deemed necessary by Cedar Crest College Health Services providers, including but not limited to:

- Physical examination
- Diagnostic procedures (e.g., lab tests)
- Administration of medications and immunizations
- Health and wellness counseling
- Referral to external services and providers when necessary, and any other diagnostic or therapeutic treatments.

I acknowledge that no guarantee or assurance has been made to me as to the results of medical treatments or examinations.

Consent to Mental Health Services

I voluntarily consent to receive mental health care and treatment as deemed necessary by Cedar Crest College Counseling Services providers, including but not limited to:

- Mental health evaluation
- Counseling
- Referral to external services and providers when necessary

Consent to Telemedicine Services

I understand that telemedicine services may be used when in-person visits are not feasible. I understand that not all conditions may be treated via telemedicine. I consent to the use of secure electronic communications for diagnosis, treatment, and follow-up care. As with any internet-based communication, I understand that there is a risk of security breach and there may be disruptions of signals or problems with the internet's infrastructure that may prevent

Cedar Crest College Health & Counseling Services
Services provided by Lehigh Valley Health Network, part of Jefferson Health
Curtis Hall 106, 100 College Drive, Allentown PA 18104

effective interaction between me and the consulting provider. I understand the risks and limitations associated with telemedicine.

I understand that I have the right to withhold or withdraw consent to any medical treatment, mental health treatment, or telemedicine services at any time.

Confidentiality and Privacy

I acknowledge that my health information is protected under HIPAA and FERPA. My information will not be disclosed without my written consent, except as required by law, as required to provide emergency treatment, or as required for medical direction or staff supervision by Lehigh Valley Health Network. I understand that Cedar Crest College Health & Counseling Services may use electronic health systems to transmit and receive my medical information securely. I have received or reviewed the Notice of Privacy Practices.

Financial Responsibility

I understand that some services offered at Cedar Crest College Health & Counseling Services may require additional fees. I understand that fees may be associated with off-campus services to which I may be referred to by Cedar Crest College Health & Counseling services, including lab tests and prescriptions. I understand that I am responsible for paying any fees associated with my receiving of services at Cedar Crest College Health & Counseling Services and personally guarantee payment of all fees or charges incurred and not paid for by my health insurance.

Acknowledgement and Signature

I certify that I have read and understand this consent form. I have had the opportunity to ask questions about this form and all of my questions have been answered to my satisfaction. I understand that this consent may be withdrawn at any time.

If you are over the age of 18, sign below:

Signature: _____ Date: _____

If under the age of 18:

Consent to medical treatment:

In the state of Pennsylvania, minors under the age of 18 may consent to medical treatment if they have graduated from high school, been pregnant, or are married. If you are under the age of 18 and meet one or more of these criteria, sign below:

Signature: _____ Date: _____

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Consent to mental health treatment:

In the state of Pennsylvania, minors aged 14 or older may consent on their own behalf to outpatient mental health treatment. If you are age 14 or older, sign below:

Signature: _____ Date: _____

If you are under the age of 18 and do not meet the criteria above, consent to treatment is required from your parent or legal guardian:

I agree that I am the parent/legal guardian of the above named student of Cedar Crest College. I agree that I have read and understand this consent form and consent to the above-named students treatment at Cedar Crest College Health & Counseling Services and that I will be personally liable for any fees or charges related to such services. I have had the opportunity to ask questions about this form and all of my questions have been answered to my satisfaction. I understand that this consent may be withdrawn at any time

Signature of Parent(s) or Legal Guardian(s)

Name: _____ Date : _____
 First Middle Last

Signature: _____

Name: _____ Date : _____
 First Middle Last

Signature: _____