



**UNG** | UNIVERSITY of  
NORTH GEORGIA™  
THE MILITARY COLLEGE OF GEORGIA®  
STUDENT HEALTH SERVICES

## Consent for Treatment

Student Name: \_\_\_\_\_ UNG ID: \_\_\_\_\_

I hereby authorize the healthcare providers at University of North Georgia Student Health Services (UNG SHS) to provide medical evaluation, diagnostic services, procedures, and treatment deemed medically appropriate by the physician, physician assistant, or nurse practitioner involved in my care. I understand that some services provided require a fee beyond the basic Student Health Fee. If I require such services, I will be made aware of the amount before the service is rendered so that I can make an informed decision about my care. \_\_\_\_\_  
(initial)

I further understand that services rendered outside of UNG SHS are not covered by the Student Health Fee and I am financially responsible for any charges associated with care, treatment, testing, medications, or other services provided by off-campus healthcare providers. \_\_\_\_\_  
(initial)

I understand that Student Health Services is committed to protecting the privacy and confidentiality of all patients. I agree not to audio record, video record, photograph, livestream, or otherwise capture any portion of a medical visit, telehealth appointment, telephone conversation, clinical procedure, or interaction with Student Health Services staff without prior authorization. I also agree to notify Student Health Services staff if any other individual is present, listening to, observing, or participating in an encounter, whether in person or remotely. Failure to comply with these requirements may result in the termination of the appointment and may affect Student Health Services' ability to provide non-emergency services. \_\_\_\_\_  
(initial)

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date