STUDENT HEALTH & WELLNESS CENTER

Student ID #: _____ Date: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____City:_____State: _____ Zip: _____

Telephone: _____ Birth Date: _____

Sex: ☐ Male ☐ Female ☐ Transgender ☐ Questioning ☐ Other: _____

Email:_____

Medi-Cal: _____Yes _____No FamilyPact: _____ Yes _____No

Health Insurance: _____ ID#_____

EMERGENCY CONTACT:

Name: _____ Telephone #:_____ Relationship: _____

Medication Allergies: _____

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Address: _____City:_____State: _____ Zip: _____

Telephone: _____ Birth Date: _____

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Email:_____

Medi-Cal: _____Yes _____No FamilyPact: _____ Yes _____No

Health Insurance: _____ ID#_____

EMERGENCY CONTACT:

Name: _____ Telephone #:_____ Relationship: _____

Medication Allergies: _____

COLLEGE OF THE CANYONS
STUDENT HEALTH & WELLNESS CENTER

Date: _____

Name:_____ Student ID #:_____

Emergency Contact:

_____ _____ _____
Name Phone # Relationship

Personal History:

1. Medication Allergies: _____

2. Medications used regularly: (i.e. thyroid, birth control, insulin, etc.):

   _____

3. Any regular use of alcohol, Marijuana, sleeping pills, street drugs, or tranquilizers?

   _____ If yes, please identify: _____

4. Do you smoke?_____ How many per day?_____

5. Past **major** medical illnesses, accidents, surgeries?

   _____

6. Any physical handicaps? (i.e., vision, hearing, etc.) Please describe:

   _____

7. Do you have a personal physician? _____

   Name:_____ Phone:_____

8. Do you have health insurance? _____

   Name:_____

9. Any other health issues or concerns? Please list:

   _____

COLLEGE OF THE CANYONS

STUDENT HEALTH & WELLNESS CENTER

GENERAL CONSENT TO TREAT

The undersigned patient and/or responsible guardian or person hereby consent to and authorize College of the Canyons' Student Health & Wellness Center providers and medical staff to administer and perform any and all consultations, examinations, treatments, designated procedures, blood draws, vaccinations and immunizations against disease which may be now or during the course of the patient's care as an outpatient be deemed advisable or necessary.

The undersigned also consents to the release of medical information to other institutions accepting the patient for care relative to continuity of care for this visit.

Date: _____

_____	_____	_____	_____
Signature of Witness		Signature of Patient	Name of Patient (Print)

_____	_____	_____
Signature of Witness	Signature of Responsible Relation or Person	Name of Responsible (Print) Relation or Person

Call Authorization:

Party authorizing care/treatment: _____ Relation to Patient:_____
Name (Print) (Print)

Staff:_____ Contact Number:_____
Name (Print)

03/22

COLLEGE OF THE CANYONS

Telehealth Informed Consent Form

California law has long recognized telehealth as a form of delivery of health care and behavioral health services which many psychotherapists are practicing in the state of CA (Business Professional Code - BPC Article 12. Enforcement 2290.5) and the U.S. In California, "Telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites. This form of service is usually live video conferencing through a personal computer with a webcam.

I _____ hereby consent to engaging in telehealth with the following College of the Canyons Student Health and Wellness Center provider(s) as part of my psychotherapy/medical treatment. I understand that "telemedicine or telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California. I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an identifiable victim and/or self; and where I make my mental or emotional state an issue in a legal proceeding.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area.

4. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. If you have an emergency, feel suicidal, or homicidal please: • Call 911 • Call the LA Psychiatric Mobile Response Team at 1-800-854-7771 • Go to the nearest Hospital Emergency Room • Call the Suicide Hotline 1-800-273-8255 available 24 hours a day. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

5. I understand that I have a right to access my medical information and copies of medical records in accordance with California law. I have read and understand the information provided above.

Signature_____ **Date**_____

Student ID_____

Full Name _____ **Date of Birth** _____

COLLEGE OF THE CANYONS

Student Health & Wellness Center

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please review it carefully.

1. This practice may use or give out your health information for the following reasons:

   Treatment:
   We give information to those involved in your care. Our staff, specialists we refer you to, pharmacists, lab personnel, as appropriate.

   To insure best practices, our pre-licensed interns under the supervision of licensed supervisors, as well as additional licensed staff within the Health Center, will consult with each other to maintain continuity of care.

   Payment:
   We give out information to get paid for our services from funding sources and/or programs that you may be enrolled in to receive benefits. (FamilyPACT and/or Student Accident Insurance)

   Health care operations:
   - Quality Assurance programs to improve our services
   - Audits by agencies funding our operation or providing benefits
   - Insurance companies to authorize services or referrals
   - Business associates as appropriate (nutritionist/mental health providers, nurse practitioners, RN, athletic trainers, etc.
   - Applications for programs/agencies designed for your specific needs
   - Contacting you. Appointment reminders, messages for follow-up exams or lab results, etc. at the contact information you provide
   - We will call your first name when the provider is ready to see you
   - Federal or state government auditing privacy practice compliance
   - Gathering health or demographic information for statistical purposes that cannot be traced back to you.

2. The health center will not use or give out health information for any reason not listed without your written authorization. You can revoke this authorization at any time.

3. The health center is required to give out health information **without your consent** in two circumstances: Required by law or public health.

4. The health center will abide by the terms of this notice but reserves the right to change the terms when necessary and provide any changes to you at the next visit. Copies of this notice will be posted in the waiting room and provided on request.

Privacy Rights

As a patient of the Student Health & Wellness Center you have the right to:

- Ask us not to share the health information in the ways described in the privacy notice. This will affect any programs you are entitled to and we may not be able to agree with your request.
- Ask us to contact you only in writing or at a different address or phone number. We will accept reasonable requests to protect your safety.
- To see a copy of your medical record. Written requests for specific information must be provided with 72 business hour notice. You may be charged a fee for copying or mailing. We may keep you from seeing all or part of the record for reasons allowed by law. Including your mental health record.
- Change the record if you believe some information we have about you is wrong. If your change request is denied, a copy of your letter will be kept in the record.
- You have the right to withdraw or revoke your authorization. If you revoke your authorization, it is only effective after the date of your written revocation, or withdrawal using the designated form.

If you want these rights explained or if you wish to file a complaint about the health center not protecting your privacy please contact:

Director of the Student Health & Wellness Center

26455 Rockwell Canyon Road
Santa Clarita, CA 91355
(661) 362-3259

Or:

Secretary of the Department of Health & Human Services by writing to: The U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877)696-6775

No Action will be taken against anyone whom files a complaint.

Date:_____ Print Name:_____

_____

Signature:

- A copy can be provided to you at any time by request.