

## STUDENT HEALTH SERVICES INFORMED CONSENT

Welcome to MSJC Student Health Center! You're viewing a three-page document that includes five (5) different sections. They are: 1. HIPAA Compliance Consent, 2. Telehealth Consent, 3. Medical Services Agreement, 4. Mental Health Consent, and 5. Patient Rights and Responsibilities. These five sections have been merged into this single document for your convenience, allowing you to sign and date once on page 3. If you wish to receive the 5 sections in separate forms, let us know and we will provide that for you. Please read this form carefully in its entirety. Your signature on page three (3) indicates that you have read and agree to all the terms and conditions put forth in all sections presented here.

### 1. HIPAA COMPLIANCE CONSENT

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, you agree that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

### 2. TELEHEALTH CONSENT

The laws that protect privacy and the confidentiality of your medical information also apply to telemedicine. The medical information that is transmitted electronically by your provider to you will be encrypted during transmission and will be stored only by your provider. The dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will NOT occur except as required by federal or California state law. While telemedicine can be used to provide improved access to medical care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission; equipment failures that could result in lost information or delays in treatment. You have a right to withhold or withdraw your consent to the use of telemedicine in the course of your care at any time, without affecting your right to future treatment and without risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

### 3. MEDICAL SERVICES AGREEMENT

**MEDICAL CONSENT:** I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the Nurse Practitioner and Physician's Assistant, staff, or other health care providers of MSJC Student Health Center assisting my care.

**FINANCIAL AGREEMENT:** I understand that all charges are due at the time of service. I agree to pay MSJC Student Health Center for all charges for healthcare services and professional services provided to me by MSJC Student Health Center. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. I agree to pay my visit in full at the time of service.

## 4. MENTAL HEALTH CONSENT

**MENTAL HEALTH CONSENT:** I understand that Mt. San Jacinto Community College Student Health Centers offer a wide range of services including personal counseling (in-person and telehealth). I understand that these personal counseling services are provided by Therapists and Therapist Trainees, who are mental health professionals. Dangers of therapy: The outcome of your treatment may depend largely on your willingness to engage in the process, which may at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We will support you and do our best to understand you and repeating patterns. If it is decided that the MSJC Student Health Center is not the appropriate agency to meet my need, I understand that I will be given referrals to resources more appropriate to my needs and goals. I am further aware that it is my responsibility to notify the Student Health Center if I am unable to be present for an appointment. Failure to do so may result in loss of services for the semester. I have read and will discuss the above information with my counselor. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Student Health Center. I acknowledge I will be offered a copy of my informed consent that explains how my Protected Health Information (PHI) will be used or disclosed by the Student Health Center and my rights as a patient and that I have received a copy of the Notice of Privacy Practices. I understand that the Student Health Center is not a 24 hour care facility and have the resources to contact in the event of an emergency outside of business hours. I, the undersigned patient authorize treatment by the Student Health Center and I have read, understand, and agree to all of the above.

**RELEASE OF MEDICAL INFORMATION:** I hereby authorize MSJC Student Health Center to release any information in my chart to any practitioner, doctor, hospital, or medical institution. Additionally, I authorize MSJC Student Health Center to provide a copy of my medical records to anyone I designate with written consent.

**NOTICE OF PRIVACY PRACTICES:** By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of MSJC Student Health Center. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting MSJC Student Health Center at (951)465-8371. **Scan the QR Code below to review the "Notice of Privacy Practices."**

**PATIENT RIGHTS AND RESPONSIBILITIES:** By signing this form, you acknowledge receipt of the "Patient Rights and Responsibilities" of MSJC Student Health Center. Our "Patient Rights and Responsibilities" provides a summary of rights and responsibilities that we believe serve as a foundation for a good relationship between patients and staff. **Scan the QR Code below to review the "Patient Rights and Responsibilities."**

**IN-HOUSE DISPENSARY:** I understand that, for my convenience, MSJC Student Health Center can dispense some prescription medications necessary to treat my medical condition(s). I understand that my insurance will not be billed for medications dispensed and that my pharmacy benefits DO NOT apply to this service. Any medication(s) dispensed in the office are my responsibility and are an additional charge. I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

**PERSONAL VALUABLES:** MSJC Student Health Center shall not be liable for the loss of, or damage to any of my personal property. MSJC, MSJC Student Health Center, and the patient or the patient's representative, hereby enter into this agreement. The undersigned certifies that he/she has read and agrees to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.



Scan the QR Code to Review Forms:



SIGNATURE: .....

NAME: .....

Date: ...../...../.....