PRINT RESET



**De Anza College Student Health Services**
21250 Stevens Creek Blvd. Cupertino, CA 95014
Phone: (408) 864-8732 Fax: (408) 864-8983

# INFORMED CONSENT FOR TREATMENT

Welcome to the De Anza College Student Health Services. The mission of the Student Health Services is to facilitate and enhance the educational success of our students by integrating high-quality, affordable health care, including health education and disease prevention.

In order to ensure the highest quality of services and to comply with professional standards, all services provided by our licensed health care providers is based on your presenting concerns and goals for treatment. Although the student health services desire to see every student function at the highest level possible, our practice provides limited comprehensive health care including diagnosis and management of minor illnesses and injury. For on-going chronic diseases and mental health issues that are beyond the level of care of student health services, the staff will assist students with community referrals.

Please be advised that we are closed during various parts of the year for holiday breaks or staff meeting and our license health care providers may not be present for medical attention due to various scheduling needs.

**Should an emergency or urgent situation arise, please call 9-1-1 or go to the nearest emergency room.**
For non-emergency questions or issues, students may call Campus Police at 650-949-7313 or the student health services main line at 408-864-8732.
For psychological services or mental health questions or issues, please call 408-864-8868. Students may also call the Santa Clara Suicide & Crisis Hotline at 408-278-4204 or text the Crisis Text Line at 741741

**AUTHORIZATION TO GIVE MEDICAL CARE – CONSENT TO TREATMENT:** I hereby voluntarily give consent to the care from De Anza Student Health Services clinical staff for medical examinations and medical treatment of illness and/or injuries, diagnostic procedures (including x-ray and laboratory tests) administration of drugs, or any other care when any or all of the foregoing is deemed necessary by, and is to be rendered under the general supervision of, a qualified California licensed health care provider. My treatment will be confidential and my records will not be released to anyone without permission, except by subpoena or other legally required reporting.

I understand that Student Health Services is limited in its ability to provide continuous or comprehensive health care as the clinic is closed in the evenings, on weekends and during holidays, and the provision of care is based on enrollment status. I understand that I may be referred to off campus medical providers if I'm not currently enrolled at De Anza College; if the medical services needed are beyond the scope, expertise, or hours of operation of the Student Health Services; or at the individual's request. I realized that individuals/families must make their own arrangements to pay for health care provided by an off-campus entity.

I also understand that during the course of treatment, Student Health Services providers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend De Anza College.

_____ **(Pt. Initial)** I agree to be contacted regarding my medical issues at the contact information below:

**Phone number:** _____
**Email to be sent to:** _____

**NOTIFICATION OF PRIVACY:** The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule gives individuals a fundamental right to be informed of the privacy practices of their health care providers and to be informed of their privacy rights with respect to their personal health information. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health care providers to exercise their rights.

All information discussed is confidential and no clinical records will appear in any academic records or transcripts. A written and signed authorization is requires before information concerning your care can be disclosed to individuals outside of the Student Health Services. At any time, you may request a printed copy of the Student Health Services Notice of Privacy Practices.

**ELECTRONIC MEDICAL RECORDS:** All protected health information in the electronic medical record is stored in a secure data center and is encrypted. Only authorized staff have access to your health information. In the unlikely event of such breach, you will be notified as required by law. In accordance with Health and Safety Code (HSC) section 1797.98 and HSC section 11191, your Student Health Services medical records will be destroyed 10 years after their receipt or production.

_____ **(Pt. Initial)** I have received the De Anza Student Health Services Notice of Privacy Practices and Patient Rights.

**TREATMENT OF MINORS:** The State of California requires parental consent prior to treatment of minors that is under the age of eighteen. There are certain situations where parental consent is not required to receive certain health care services if they meet the legal requirements, to include mental health counseling; alcohol and drug abuse counseling; diagnosis, treatment and preventive care for sexually transmitted diseases; and care related to pregnancy and pregnancy prevention. Individuals under the age of eighteen may be able to consent to their own health care based of their status or living situation.

**Please check one of the following:**

☐ **I'm able to consent to my own care, because:**

- ○ **I am 18 years old or older**
- ○ **I am or have been married, in the armed forces, or have been emancipated by court**
- ○ **I am 15 years old or older, living separate and apart from my parents, and managing my own financial affairs (must meet all requirements)**

☐ **I am seeking "MINOR CONSENT SERVICES"**

- ○ **I am under the age of 18 and does NOT MEET the legal requirements above.**

**I have read, understand** and **give consent** to the above information and polices and have provided an opportunity to review and ask question.

_____ _____ _____

Patient Name Date of Birth Student ID #

_____ _____

Patient Signature Date

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# INFORMED CONSENT FOR VIRTUAL VISIT SERVICES

| Patient Name: | | Date of Birth: | | SID#: |
|---|---|---|---|---|
| Patient Address: | City: | State: | Zip: | Date Consent Discussed: |

**PURPOSE:**

The purpose of this form is to obtain your consent to participate in a virtual visit consultation in connection with the basic health care services provided by the De Anza College Student Health Services.

Virtual Visit Services/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**EXPECTED BENEFITS**

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the providers obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

**POSSIBLE RISKS**

As with any medical procedure, there are potential risks associated with the use of virtual visit services/telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the providers and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page: _____

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## INFORMED CONSENT FOR VIRTUAL VISIT SERVICES

*BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:*

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to virtual visit services/telemedicine, and that no information obtained in the use of virtual visit services/ telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of virtual visit services/telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of virtual visit services/telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. The De Anza College Student Health Services has explained the alternatives to my satisfaction,
5. I understand that virtual visit services/ telemedicine may involve electronic communication of my personal medical information to other providers who may be located in other areas, including out of state.
6. I understand that it is my duty to inform the De Anza College Student Health Services of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of virtual visit services/telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of California and will be present in the state of California during all virtual visit encounters with the De Anza College Student Health Services.

### PATIENT CONSENT TO THE USE OF VIRTUAL VISIT SERVICES

I have read and understand the information provided above regarding virtual visit services/telemedicine, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize De Anza Student Health Services to use virtual visit services/telemedicine in the course of my consultation, diagnosis and treatment.

**PATIENT'S SIGNATURE** (OR AUTHORIZED PERSON TO SIGN FOR PATIENT) **DATE**

**IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT** **DATE**

**WITNESS** **DATE**

I have been offered a copy of this consent form. _____ (Patient's Initials)

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# NO SHOW/MISSED APPOINTMENT POLICY

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

As a courtesy, an appointment reminder call or email to you is made/attempted **one (1) business day** prior to your scheduled appointment. However, it is your responsibility to arrive **on time** on your appointment.

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible and **no later than 24 hours prior to your scheduled appointment.** This gives us time to schedule other patients who may be waiting for an appointment.

Failure to cancel or reschedule without a 24-hour notice will result in a **$10.00 fee.**

**Please review our No Show Policy below:**

1. If you must cancel or reschedule an appointment, please call 24 hours in advance. A 24-hour notice is defined as one business day. Messages left over the weekend are not considered sufficient notice.

2. Any **new or established patient** who fails to show or cancel or reschedule an appointment and has not contacted our office with at **least 24 hour-notice will be considered a" No Show" and will be charged the fee**. This will be documented as a "No-Show" appointment. The Student Health Services staff will assist you to reschedule this appointment if needed **after the fee is paid.**

3. No further appointments will be scheduled until the No-Show fee has been reconciled.

**I have read and understand** De Anza College Student Health Services No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the Student Health Services appropriately if I have difficulty keeping my scheduled appointments.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Date of Birth | Student ID # |

| _____ | _____ |
|---|---|
| Patient Signature | Date |