SANTA ANA COLLEGE
Health and Wellness Center

1530 W. 17th Street, JSC-110, Santa Ana, CA 92706
T: 714 564 6216 I F: 714 558 3732
E: Sachealth_Center@sac.edu

Face Sheet

Date: _____ Student/Employee ID: _____

Last Name: _____ First Name: _____ Middle Initial: ____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Ethnicity: _____ Legal Sex: ☐ Male ☐ Female

Contact Information

– Phone: _____ ☐ *Ok to contact* ☐ *Ok to text*

Mobile Carrier: _____ w/sensitive information

– Email: _____ ☐ *Ok to Email*

Do you have allergies? ☐ *Yes* ☐ No

Allergic to:	Reaction

Emergency Contact

Name: _____Relationship: _____

Phone: _____ ☐ *Ok to call?*

Address: _____

City: _____ State: _____ Zip Code: _____

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Medical Services

General Consent to Treatment and Telehealth

I _____ (The undersigned patient and/or parent or guardian) hereby consent to and authorize Santa Ana College Health & Wellness Center's physicians and medical personnel to administer and perform any and all medical examinations, treatments, designated procedures, vaccinations and immunizations against disease which may be now or during the course of the patient's care advisable or necessary. I hereby consent to the release of medical information to other internal entities and external institutions relative to continuity of care for services rendered in the Health & Wellness Center. The HIPAA Law governing patient information is posted in the Health & Wellness Center for you to read, if desired, before signing this consent.

TELEHEALTH

I also consent to engaging in telehealth with personnel at the Santa Ana College Health and Wellness Center who reserves the right to change its service delivery model in response to updated information, including state and national directives. "Telehealth" is interchangeable with "telemedicine". "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site, and the health care provider is at a distant site.
Telehealth medical services will occur primarily through interactive audio, video, telephone, email, instant messaging, and/or other data communications.

I understand and agree to the following with respect to telehealth:

(1) To receive telehealth services, the patient must be physically located in the State of California where the telehealth provider is licensed at the time of the appointment. Telehealth service may not be provided in interstate and international jurisdictions.

(2) I understand that there are risks and consequences from telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of the medical provider, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/ or the electronic storage of my personal information could be accessed by unauthorized persons.

(3) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of telehealth, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.

(4) I am responsible for finding a private location where the session(s) may be conducted.

(5) I understand that Telehealth care is a form of treatment that may involve limitations described above. I also understand that if my provider believes I would be better served by another form of intervention, I will be referred to a medical professional who can provide such services in my area.

AFTER-HOURS EMERGENCIES

If I am in crisis or in an emergency, I will immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. I acknowledge I have been told that if I feel suicidal, I am to call:

- 9-1-1
- Call or Text National Suicide Prevention Lifeline at 1-800-273-8255
- Crisis Text Line Text "COURAGE" to 741-741

NO SHOW/LATE CANCELLATION POLICY

If you have two no shows or late cancellations in an academic year, you will no longer be eligible for ongoing services until the next academic year.
Any student may submit a no show/late cancellation policy exception form. Forms are submitted to the Health and Wellness Center director for approval.

- To obtain the exception form e-mail: sachealth_center@sac.edu or visit the Health and Wellness Center front desk.

Approved exception forms do not count toward the two no-show/late cancellation appointments.

Exceptions

- Students will be eligible for crisis services regardless of number of no-show/late cancellation appointments.
- If you arrive late for a medical appointment or ongoing psychological services appointment, it is at the discretion of your clinician if you will been seen.
- After two no-show or late cancellations, a student may be eligible for reinstatement of services at the Health and Wellness center.
    - In order to be reinstated, a student must schedule an appointment to meet with the HWC director
    - Students may schedule this appointment by phone or in-person

Definition of Late Cancellation:

a. A scheduled appointment canceled with less than 24 hours in advance.

b. If you arrive less than 10 minutes early for your first psychological services appointment (intake), your appointment will be considered a late cancellation and re-scheduled. This does not apply to medical appointments.

Definition of No Show:

a. A no show is failure to come to a scheduled appointment.

I acknowledge that I have read, understand, and agree to abide by the information outlined above. I hereby give my consent to authorize Santa Ana College Health and Wellness Services to evaluate, treat, and/ or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information.

_____ _____
Signature Date

_____ _____
Name (PLEASE PRINT) ID #

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HIPAA Notice of Privacy Practices

I. HOW WE MAY USE OR DISCLOSE YOUR PRIVATE HEALTH INFORMATION (PHI)

A. **Treatment**: We may use or disclose your PHI to provide you with medical treatment or services. For example, information obtained by a provider providing health care services to you will record such information in your record that is related to your treatment. This information is necessary to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond. For patients receiving Substance Use Disorder (SUD) services, we may use or disclose your SUD records for treatment purposes based on a single prior written consent. Once given, this consent remains valid for all future treatment uses and disclosures until you revoke it in writing.

B. **For health care operations**: We may use or disclose your PHI in order to operate our facilities. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provide health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us. When SUD records are involved, we may use or disclose such records for these operations based on a single prior written consent that remains valid until revoked. Once SUD records are disclosed to a HIPAA-covered entity for health care operations or treatment, they may be further disclosed by that entity in accordance with HIPAA regulations, provided they are not used in legal proceedings against you.

II. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR CONSENT

We may use and disclose your PHI without your consent or authorization for the following reasons:

A. **When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement**: For example, we make disclosures when law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; or when ordered to do so in judicial or administrative proceedings. The use or disclosure of Substance Use Disorder records in any legal proceeding against you—regardless of whether the proceeding is civil, criminal, administrative, or legislative—is strictly prohibited unless the stringent requirements of 42 CFR Part 2, including a specific court order or explicit patient consent, are met.

B. **For public health activities**: For example, we report information about births, deaths, and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death. SUD-specific records may only be disclosed to public health authorities in a de-identified format, unless other specific criteria under 42 CFR Part 2 are satisfied.

C. **For health oversight activities**: For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

D. **For purpose of organ donation**: We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

E. **For research purposes**: In certain circumstances, we may provide PHI in order to conduct medical research. SUD records used for medical research must adhere to the same stringent protections as other PHI, requiring specific HIPAA-compliant safeguards and 42 CFR Part 2 alignment to ensure patient anonymity.

F. **To avoid harm**: In emergency situations, in order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm. In emergency situations involving SUD records, the disclosure is limited to the minimum information necessary to treat the specific emergency condition.

G. **For specific government functions**: We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

H. **For workers' compensation purposes**: We may provide PHI in order to comply with workers' compensation laws.

I. **Appointment reminders and health-related benefits or services**: We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

III. USES AND DISCLOSURES THAT REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT

Disclosures to family, friends, or others: We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care of the payment for your health care, unless you object in whole or part. The opportunity to consent may be obtained retroactively in emergency situations.

IV. ALL OTHER USES AN DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

In any other situation not described in the above sections, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

V. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The right to request limits on the uses and disclosures of your PHI**: You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The right to choose how we send PHI to you**: You have the right to ask that we send information to you at an alternate address or by alternate means (for example, fax instead of regular mail). We must agree to your request so long as we can easily provide it in the form you requested.

C. **The right to see and get copies of your PHI**: In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. In certain situations, we may deny your request. If we do, we will tell you in writing our reason for the denial and explain your right to have the denial reviewed. There may be charges for copies made.

D. **The right to get a list of the disclosures we have made**: You have the right to get a list of instances which we have disclosed your PHI. The list will not include uses or disclosures for treatment, payment, health care operations, directly to you, to your family personal representative. The list also won't include uses and disclosures made for national security purposes, corrections, or law enforcement personnel. It does not include uses and disclosures for which you gave written authorization.

E. **The right to correct or update your PHI**: If you believe there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is:
    i. correct and complete,
    ii. not created by us,
    iii. not allowed to be disclosed, or
    iv. not part of our records.

Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file such statement, you have the right to request that your statement and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make changes to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

VI. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may:
i. contact the supervisor of the area of your concern,
ii. send a written complaint to the Secretary of the Department of Health and Human Services.

We will take no retaliatory action against you if you file a complaint about our privacy practices.
I have read and understand the HIPAA Notice of Privacy Practices for Santa Ana College Health and Wellness Center.

Signature:_____ Date:_____ Witness:_____