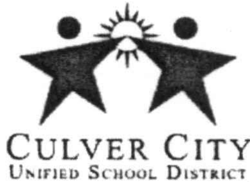

Consent for Medical and Mental Health Services

I give my consent for ________________________ to receive medical care, counseling, mental health services, reproductive health services, health education, and/or referral services at Culver City Youth Health Center in conjunction with The Los Angeles Child Development Center and Venice Family Clinic. I have completed the registration and health forms including insurance information and income sections.

I understand that some services are confidential and that the Culver City Youth Health Center, The Los Angeles Child Development Center, and the Venice Family Clinic may be prohibited by law from releasing some information to parents or guardians.

I further authorize Culver City Youth Health Center, The Los Angeles Child Development Center, and Venice Family Clinic to release medical/social information to persons or agencies directly concerned with public health or community welfare, private individuals professionally engaged in carrying out a treatment plan for the patient, for obtaining pharmaceuticals, and billing purposes. I understand that this consent form remains in effect until revoked in writing.

- ☐ I give consent to all services available through Culver City Youth Health Center, The Los Angeles Child Development Center, and Venice Family Clinic. *Please be aware that minors, by law can self-consent for certain services.*

____

Print Name of Parent/Guardian — Relationship to Student

____

Signature of Parent/Guardian — Date

____

Address of Parent/Guardian — Phone Number

In partnership with Culver City Youth Health Center, The Los Angeles Child Development Center and Venice Family Clinic.

Registration form, please print: Chart #________________

Name of patient ____ Birth date: _____________
Address ____ Social Security # _____________
____ Sex _____________
Home Phone # __________________________ Work Phone # _________________________
Name of patient's Mother________________________ Father_________________________

Friend or Relative to be contacted in case of an emergency:
Name: ______________________________________ Emergency Phone # _______________

RACE:
__(1) African American
__(2) Asian/Pacific Is.
__(6) Other
__(7) Native American/Alaskan
__(8) Caucasian
__(9) Unknown
__(10) Native Hawaiian
__(11) Other Pacific Islander

ACCOUNT TYPE: ( )
__(1) Medi-Cal #______________
__(2) Medicare #______________
__(3) None
__(4) Medi-Medi
__(17) PPP
__(12) GR # __________________

Health Insurance: ______________
Deductible $ __________________

LANGUAGE:
__(1) English
__(2) Spanish
__(3) Russian
__(4) Other

Marital Status:
__(S) Single
__(M) Married
__(L) Separated
__(D) Divorced
__(W) Widowed

Hispanic/Latino Origin (Y / N)?

Occupation:

List family members who live with patient and are supported by the family income	Relationship to the patient	Year of birth	Source of income	Monthly Income
1. Patient	Self			$
2.				$
3.				$
4.				$
5.				$
6.				$
7.				$
8.				$

Total Monthly Gross Income $____________

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.
Signature: ______________________________________ Date Signed: ____/____/___
Mo. Day Yr.