Sandy Segal Youth Health Center

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 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 and the Venice Family Clinic may be prohibited by law from releasing some information to parents or guardians. I understand that parental consent is not required for certain health care services, such as diagnosis and treatment of sexually transmitted diseases, reproductive health care, and mental health care.

I understand that all information between me and the Venice Family Clinic (VFC) is held strictly confidential and does not become part of the student school record unless: (1) a Release of Information is authorized by means of my signature or parent/legal guardian of a minor; (2) VFC is ordered by a court of law to release information; (3) child abuse or neglect is suspected; (4) elder/dependent/disabled abuse or neglect is suspected; (5) I am a physical danger to self (suicidal) or others (homicidal); (6) child pornography is suspected; (7) insurance requests demographic, diagnostic, and outcome measures. In cases of suspected danger, VFC is required by law to take steps to inform legal authorities, to hospitalize, or to contact potential victims so that we can help protect patients or others. Information between a therapist and a minor is protected when the youth is mature enough to consent for treatment (typically 12 years and older).

I understand that counseling is intended to reduce or eliminate symptoms of distress and to improve work and social functioning. Counseling has both benefits and risks and, as with all treatments, the outcomes are not guaranteed. Treatment relies primarily on talking and education, and never touch. Risks may include experiencing or talking about uncomfortable feelings such as sadness, guilt, anxiety, frustration and helplessness. The benefits, however, include a significant reduction in feelings of distress, increased satisfaction with relationships, greater insight, and improved skills for managing stress. I understand that my therapist and I work together toward mutually agreed upon goals. Therapy relies on the effort on my part. To have the most success, I will try to arrive on time and work towards my goals in between sessions.

I further authorize Culver City Youth Health 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 and Venice Family Clinic. *Please be aware that minors, by law can self-consent for certain services*.

Print Name of Student	Signature of Student	Date

Print Name of Parent/Guardian	Relationship to Student

Signature of Parent/Guardian	Date

Address of Parent/Guardian	Phone Number

Venice Family Clinic

Culver City Unified School District

In partnership with Culver City Youth Health Center and Venice Family Clinic.

Registration form, please print: Chart #_____

Name of patient_____ Birth date_____

Address_____ Social Security # _____

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

Hispanic/Latino Origin? Y / N

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] Widow

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.