VENTURA COLLEGE STUDENT HEALTH CENTER

Fee Payment Information

We are committed to providing you with quality and affordable health care.

1. **Services that require additional fees over and above the mandatory student health fee:**

   ***Physicals –** EMT, AND (Nursing), CNA, PM (Paramedic), Child Dev., Phlebotomy, Medical Assistant, University, Work (No DMV Physicals)
   ***Vaccinations –** MMR, Flu, TDAP, Hep B, Hep A, TB Skin Test
   ***In House Prescriptions –** Antibiotics
   ***Lab –** Blood tests, Pregnancy tests

   All students will be provided a receipt for these above services. The fees are posted to your student account.

2. **Missed Appointments –** The health center charges for missed appointments that are not canceled within a reasonable amount of time (24 hours). The fee for a missed appointment is $10.00. These charges will be billed directly to your student account.
   ****Staff will be charged $35 for a repeat PPD**

3. **Insurance** – We do not bill health insurance plans.

Please let us know if you have any additional questions regarding this information.

I have read and understand the above information and agree to abide by these guidelines:

_____ _____

Student/Parent/Guardian Signature (If Minor) **Date**

VENTURA COLLEGE
STUDENT HEALTH CENTER
4667 TELEGRAPH ROAD, CRC-108
VENTURA, CA 93003
(805)654-6346

NAME_____ **BIRTHDATE**_____ **900#**_____

CONFIDENTIAL MEDICAL/HEALTH HISTORY

Indicate if there have been any of the following diseases in you, parents, grandparents, siblings or children.

_____Y_____N	ARTHRITIS	_____Myself _____	Family (relationship) _____
_____Y_____N	ASTHMA	_____Myself _____	Family (relationship) _____
_____Y_____N	CANCER	_____Myself _____	Family (relationship) _____
_____Y_____N	DIABETES	_____Myself _____	Family (relationship) _____
_____Y_____N	FAINTING/DIZZINESS	_____Myself _____	Family (relationship) _____
_____Y_____N	FREQUENT HEADACHES	_____Myself _____	Family (relationship) _____
_____Y_____N	HEART PROBLEMS	_____Myself _____	Family (relationship) _____
_____Y_____N	HIGH BLOOD PRESSURE	_____ Myself _____	Family (relationship)_____
_____y_____N	KIDNEY DISEASE	_____Myself _____	Family (relationship) _____
_____Y_____N	MENTAL HEALTH	_____Myself _____	Family (relationship) _____
	Diagnosis:_____		
_____Y_____N	SEIZURES/CONVULSIONS	____Myself _____	Family (relationship) _____
_____Y_____N	TUBERCULOSIS	_____Myself _____	Family (relationship) _____
_____Y_____N	ULCERS	_____Myself _____	Family (relationship) _____

_____Y_____N PERMANENT DISABLITY / CHRONIC ILLNESS – DESCRIBE _____

_____

_____y_____N OTHER – DESCRIBE _____

Do you use tobacco products? _____Y_____N _____ Smoke _____Chew **Interested in quitting? __Y__N**
Do you use alcohol products? _____Y _____ N
On average, how many days a week do you have an alcoholic drink? _____
On a typical drinking day, how many drinks do you have? _____
Do you use recreational drugs? _____Y_____N (ie. Marijuana, Ecstasy, Amphetamines)_____

_____

Are you under a doctor's care at present?_____Y_____N If yes for what?_____
Who is your primary care physician / clinic? _____
What type of health insurance do you have? _____
What type of medications (prescriptions, over-the-counter, supplements, herbs, etc.) are you currently taking:_____

_____

Are you **HYPERSENSITIVE or ALLERGIC** to foods, drugs, or environmental substances? Please list:

_____

Do to the increase in HIV in our community we are required to ask if you would be interested in being tested for HIV. We offer it for $8, or can refer you to a place that offers it for free. (Please check applicable box)

□ Would like to be tested today □ Would like more information □ N/A at this time

Student/Parent/Guardian Signature (if minor)_____ **Date:**_____

For office use only

Medical/Health History Reviewed by:_____ **Date Reviewed:**_____

FOR OFFICE USE ONLY

Reviewed By: _____

Date: _____

Phone Number & Emergency Contact Updated By: _____

Date: _____

VENTURA COLLEGE
STUDENT HEALTH CENTER
4667 TELEGRAPH ROAD
VENTURA, CA 93003
(805)289-6346

DEMOGRAPHICS

STUDENT_____ STAFF_____900#:_____ BIRTHDATE:_____

LAST NAME:_____ FIRST NAME:_____ MIDDLE:_____

Preferred name if different from above:_____

I identify my sex as: (check all that apply)
□ Male □ Female □ Intersex □ MtF Female □ FtM Male □ Other_____
I identify my gender as: (check all that apply)
□ Male □ Female □ Trans □ Cis □ Other_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL:_____

EMERGENCY CONTACT:_____ PHONE:_____
RELATION:_____

CONSENT FOR TREATMENT AND LIMITS OF CONFIDENTIALITY

I HEREBY GRANT VENTURA COLLEGE STUDENT HEALTH CENTER PERMISSION TO TREAT AND/OR MAKE NECESSARY REFERRALS FOR MEDICAL/PSYCHOLOGICAL CARE, IF NEEDED. I ALSO UNDERSTAND THAT THE VENTURA COLLEGE STUDENT HEALTH CENTER IS NOT A PRIMARY CARE PROVIDER AND THEREFORE THEY ARE UNABLE TO MANAGE CHRONIC ILLNESS. I UNDERSTAND THAT MY MEDICAL RECORDS ARE KEPT CONFIDENTIAL IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY PRACTICES. I HAVE RECEIVED AN OVERVIEW OF THE VENTURA COUNTY COMMUNITY COLLEGE DISTRICT STUDENT HEALTH CENTER NOTICE OF PRIVACY PRATICES. I UNDERSTAND I MAY REQUEST A COPY OF THE POLICY IN ITS ENTIRETY AT ANY TIME. I ALSO UNDERSTAND THERE IS A COPY OF SAID POLICY POSTED IN THE STUDENT HEALTH CENTER FOR MY REVIEW.

_____ DATE:_____
PATIENT/PARENT/GUARDIAN SIGNATURE (IF MINOR)

FOR YOUR INFORMATION: This office may use student workers to assist with health services. The person who checks your "vitals" – blood pressure, pulse, etc. may not be a licensed nurse. The students are qualified to take your vital signs; however, they are NOT qualified to suggest treatments and/or a diagnosis. You are not required to tell them the reason for your visit unless you are comfortable doing so. You may state "Confidential" regarding the reason for the visit.

Please initial _____

Ventura College Student Health Center
NOTICE OF PRIVACY PRACTICES
OVERVIEW

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Student Health Center has voluntarily chosen to adhere to the privacy rules established by The Health Insurance Portability and Accountability Act (HIPAA) of 1996.
The Student Health Center is not an entity required to abide by HIPAA regulations.

Uses and Disclosures

The Student Health Center (SHC) use health information about you for treatment, to obtain payment for treatment at the Business Office, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. The SHC may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your Rights

In most cases, you have the right to look at or receive a copy of health information about you. If you request copies, the SHC will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we have made. If you believe that information in your record is incorrect, you have the right to request that it be corrected.

Our Legal Duty

The SHC is required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgment of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of the notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that the SHC has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Mary Jones, Student Health Center Coordinator or her appointed designee
Ventura College Student Health Center
4667 Telegraph Road
Ventura, CA 93003
(805) 289-6346
(805) 289-6098 fax