General Consent
I hereby give consent to the clinical staff (including interns and trainees) of the Student Health Center (SHC) of California State University, Los Angeles (CSULA) for medical examination, diagnostic procedures (including x-ray, laboratory tests), administration of medical or surgical treatment, or part of training procedures, or for 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. While this authorization is given in advance of any medical care being rendered, I understand that a reasonable effort will be made to contact me for consent in the event medical treatment is required as allowed by law.

Chiropractic Consent
I hereby give consent to the Los Angeles College of Chiropractic interns at the CSULA SHC for examination and chiropractic treatment to be rendered under the general supervision of a qualified California licensed Doctor of Chiropractic. I understand that as in the practice of medicine, in the practice of alternative clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments, the most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to, fractures, strokes, dislocations, sprains, burns and aggravation of disc injuries. I understand that if I receive acupuncture and oriental medicine treatments the risks included but are not limited to: minor bleeding, local bruising, fainting, temporary pain or discomfort and the possible temporary aggravation of prior existing symptoms. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests. For no show and late cancellation fees, please see information under No Show and Late Cancellation.

Acupressure and Massage Consent
I hereby give consent to the Massage Therapist of the CSULA SHC for examination and administration of acupressure treatment, table or chair massages to be rendered under the general supervision of a qualified California licensed health care provider. I understand that in the practice of alternative clinical therapies, as in the practice of medicine, there are some risks to treatment. I understand that if I receive acupressure treatment, table or chair massages the risks include but are not limited to: local bruising, dizziness, temporary pain or discomfort and the possible temporary aggravation of prior existing symptoms. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him/her to exercise judgment during the course of the procedure which he/she feels at the time, based on the facts know then, is in my best interest. For no show and late cancellation fees, please see information under No Show and Late Cancellation.

Dental Consent
I hereby give consent to the Dentist of the CSULA SHC to perform an examination of the teeth, mouth and neck, x-rays of the teeth and jaw, cleaning of teeth and application of fluoride, application of plastic dental sealants to the grooves of molars, use of local anesthesia to numb the teeth and surrounding tissues, treatment of injured or diseased teeth with tooth colored fillings (composites) and amalgam fillings. I understand that the Dentist has explained the nature and purpose of the treatment and procedures to me in general terms. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages, disadvantages, risks, consequences, and probable effectiveness of each, as well as prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications from dental procedures cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the procedure, treatment, or cure. For no show and late cancellation fees, please see information under No Show and Late Cancellation.

California State University, Los Angeles
STUDENT HEALTH CENTER

AUTHORIZATION AND CONSENT FOR TREATMENT
Health and Nutritional Sciences
I hereby give consent to the CSULA School of Kinesiology and Nutritional Sciences (KNS) Coordinated Dietetics Program intern at CSULA SHC for nutritional assessment and nutritional counseling rendered under the direction of a KNS faculty registered dietitian. I understand that my nutritional assessment and counseling information will become a part of my confidential medical record.

Optometry Consent
I hereby give consent to the Optometrist of the CSULA SHC to perform an examination of the eyes to test and detect eye problems such as nearsightedness, farsightedness, or more serious eye conditions such as glaucoma. This eye examination will enable the optometrist of CSULA SHC to identify an appropriate prescription corresponding to my condition and recommend corrective eyeglasses or contact lenses to help maintain optimum visual health.

Medical Records Confidentiality
I understand that my treatment will be confidential and my medical records will not be released to anyone without my written permission except for the purpose of the SHC’s licensing and accreditation, by subpoena, or other legally required reporting. I understand that the SHC’s Continuous Quality Improvement Team conducts reviews of medical records to ensure the appropriateness, necessity, and the quality of services, and that my medical records may be included in this review.

Authorization and Consent for Treatment
I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner; and I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I make known that I choose to terminate it.

I understand that the SHC is limited in its ability to provide continuous and/or comprehensive health care for me as the SHC is closed in the evenings, on weekends, during holidays, and the provision of care is based on enrollment status and California State University Policy.

No Show and Late Cancellation Fee
I hereby acknowledge that I will be charged a $10 no-show/late cancellation (NSLC) fee if I fail an appointment or do not cancel at least 12 hours before the appointment time. I understand that if I do not pay the fee within 7 days from the date of notice, a registration hold will be placed on the University’s PeopleSoft Data Information System, preventing me from being able to add/drop/withdraw from classes. This fee applies to Chiropractic, Dental and Massage clinics.

Acknowledgement of the Notice of Privacy Practices
I hereby acknowledge that I have been given the opportunity to read the SHC’s Notice of Privacy Practices. I understand that I may request a copy from the SHC staff or by visiting the SHC’s website.