PSUSD Mental Health Services
333 S. Farrell Drive. Palm Springs, CA 92262

Consent for Outpatient Treatment

1. Outpatient services may include assessment; diagnosis; crisis intervention; individual, group, or family therapy; day treatment services; training in daily living and social skills; prevocational training; and / or case management services. Outpatient services are provided by qualified professional staff members of the Palm Springs Unified School District Mental Health Team.
2. Outpatient treatment may consist of contacts between qualified professionals and clients, focusing on the presenting problem and associated feelings, possible causes of the problem and previous attempts to cope with it, and possible alternative courses of action and their consequences. The frequency and type of treatment will be planned by you and the treatment staff.
3. You are expected to benefit from treatment, but there is no guarantee that you will. Maximum benefits will occur with regular attendance, but you may feel temporarily worse while in treatment.
4. Failure to keep your appointment or to follow treatment recommendations may result in your treatment being discontinued. If you cannot keep your appointment, you are expected to notify the Mental Health Program at **(760) 416-1360 or notify via email at MentalHealthServices@psusd.us.**
5. All information and records obtained in the course of treatment shall remain confidential and will not be released without your written consent except under the following conditions:
    a. You are a non-emancipated minor, ward of the court, or an LPS conservatee.
    b. To government law agencies to protect the lives of federal and state elective constitutional officers and their families.
    c. To the courts if subpoenaed or if otherwise necessary for the administration of justice.
    d. To the extent necessary to prevent harm to reasonable foreseeable victim if a client presents a danger of violence to others (Welfare & Institution Code 5328r).
    e. To Juvenile authorities when child abuse is observed or suspected (Penal Code Section 11165, et.seq).
    f. To Adult Protective Services when elder abuse is observed or suspected (W&I Code Section 15630, et.seq).
    g. To prevent self-induced harm or death (Johnson vs. County of Los Angeles, 1983).
    h. To certain employees of the Mental Health Department and its contract agencies, and to certain community health providers (including exchange of information between the Mental Health Plan and the client's community providers authorized by the MHP), as necessary for treatment and administrative purposes.
    i. To the Calif. Dept. of Health Services as required by them for research and tracking purposes (including your name and identifying information).
    j. Under certain circumstances as set forth in W&I Code Section 5328 through 5328.15, which you may read upon request.
6. You have the right to accept, refuse, or stop treatment at any time.
7. I have received the Notice of Privacy Practices, which explains the limits of ways Palm Springs Unified School District – Mental Health Services may use or disclosure personal health information to provide such services.
   I have a paper copy of the Notice of Privacy Practice,
8. The Medi-Cal eligibility individual if applicable (to include parents/guardians of Medi-Cal eligible children/adolescent has been informed : Acceptance and participation in the mental health Medi-Cal reimbursement and have the right to request a change of provider, staff person, therapist, coordinator, and/or case manager to extent permitted by law.
9. I understand that a Mental Health Diagnosis does not necessarily constitute eligibility for Special Educational Services in the district.
10. I have been offered the Consumer Handbook via . * Initial

INITIAL HERE

I have read the above, and I agree to accept treatment, and I further agree to all conditions set forth herein. I acknowledge that I have received a copy of this agreement.

_____ _____
Student/Client Signature Date

SIGN HERE

_____ _____
Parent / Guardian / Conservator Signature Date

_____ _____
Witness Signature Date

PALM SPRINGS UNIFIED SCHOOL DISTRICT
MENTAL HEALTH

AUTHORIZATION FOR USE AND/ OR DISCLOSURE OF INFORMATION

Student Name _____ D.O.B: _____ Gender: _____

Student Address: _____

Phone Number: _____ Alternate Phone Number: _____ Email: _____

I authorize the following individuals or organization to disclose the above-named individual's medical/educational information as described below:

Individual/Organization ☐ **Receiving** ☐ **Disclosing**		**Individual/Organization** ☐ **Receiving** ☐ **Disclosing**	
Palm Springs Unified School District Mental Health Services		PSUSD /	
Address: 333 S. Farrel Dr.		Address: 150 District Center Drive	
City, State, Zip Code Palm Springs, CA 92262		City, State, Zip Code Palm Springs, CA 92264	
Telephone Number: 760-416-1360	Fax Number: 760-416-1362	Telephone Number:	Fax Number:
Email: MentalHealthServices@psusd.us		Email:	

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (*date*) or for one year from the date of signature if no date is entered.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt but will not apply to information that has already been released in response to this authorization.

Redisclosure: I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

Health Info: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization, and I do not need to sign this form in order to assure medical treatment.

Specify Record(s): Indicate type of information is to be disclosed:

Medical ☐	Medication ☐	Psychiatric ☐
Mental Health ☐	Vision ☐	Drug / Alcohol ☐
STD/HIV Test Results ☐	Educational ☐	Audiological ☐
Other:		

Any and all information with regard to the above records may be release expect as specifically provided here:

I requested that the information released pursuant to this authorization be used for the following purposes only:

Educational Assessment ☐	Educational Planning ☐	Other: ☐

A copy of this authorization is as valid as an original.
I understand that I have a right to receive a copy of this authorization for my records.

SIGN HERE

_____ _____ _____

Signature of Student or Student's Representative **Description of Relationship to Student** **Date**

OPTIONAL FORM (replacing SELPA FORM 9001E 05-06)

Client Resource Evaluation

All items below must be completed.

RESOURCES NEEDS (appropriate to client/s or students' desires and culture)

Income:	Yes ☐	No ☐
Food:	Yes ☐	No ☐
Housing:	Yes ☐	No ☐
Medical Care:	Yes ☐	No ☐
Education:	Yes ☐	No ☐
Employment:	Yes ☐	No ☐
Volunteer Opportunities:	Yes ☐	No ☐
Preparation for Work:	Yes ☐	No ☐
Childcare:	Yes ☐	No ☐
Transportation:	Yes ☐	No ☐
Legal Advice:	Yes ☐	No ☐
Immigration Assistance:	Yes ☐	No ☐
Other:		

SIGN HERE

Student Name: _____ Student ID#: _____

_____ _____ _____ _____

Provider Signature/Printed Name Date Client Signature/Printed Name Date

CLIENT RESOURCE EVALUATION

PSUSD MENTAL HEALTH SERVICES

333 S. Farrell Drive, Palm Springs CA 92264

Tel: (760) 416-1360 Fax: (760) 416-1362

Email: MentalHealthServices@psusd.us

CONFIDENTIAL PATIENT INFORMATION

SEE W&I CODE 5328

Acknowledgement Receipt of Notice of Privacy Practices
PATIENT ACKNOWLEDGEMENT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of this entity and all others included in the County of Riverside Hybrid Entity.

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site at RUHealth.org or contacting the Privacy Office at (951) 486-4659.

If you have any questions about our Notice of Privacy Practices, please contact the Privacy Office at (951) 486-4659.

Signature of Patient/Legal Representative

Print Name of Patient/Legal Representative

Date and Time of Signature

INABILITY TO OBTAIN PATIENT ACKNOWLEDGEMENT

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____An emergency situation prevented us from obtaining acknowledgement, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

_____Patient incapacitated/unable to sign

_____Other (Please specify): _____

Signature of Hospital Representative

Date and Time

PALM SPRINGS UNIFIED SCHOOL DISTRICT - MENTAL HEALTH SERVICES

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

Patient Name:_____ Medical Record #_____

I, _____, hereby consent to engaging in telemedicine/telehealth services as part of my behavioral health treatment with the Palm Springs Unfied School District (PSUSD), I understand that telemedicine / telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

I understand that telemedicine/telehealth services will not be the same as a face-to-face visit and that there could be risks, including but not limited to, the possibility, despite reasonable efforts on the part of PSUSD that the transmission of my medical information could be disrupted or distorted by technical failures. Furthermore, I understand that despite the security measures taken on the part of PSUSD to prevent electronic tampering, transmission of my medical information could be interrupted by unauthorized persons.

I understand that individuals may be present during the telemedicine/telehealth session to operate the audio/video equipment and provide clinical assistance at the direction of the presenter. I understand these individuals must maintain the confidentiality of my health information that is disclosed during the telemedicine/telehealth session.

I understand that the dissemination of any personally identifiable images or information from the telemedicine/telehealth session may not be released without my written consent.

I understand that I may terminate this consent at anytime without affecting my right to future care or treatment.

I understand that I am responsible for ensuring the privacy of my conversation if I choose to receive telemedicine/telehealth services at a non-County operated site.

I have read and understand the information provided and all of my questions have been answered to my satisfaction.

_____ _____

Patient/Representative Signature Date

This consent expires one (1) year from the date of signature.