Pasadena City College
Student Health Services
1570 E. Colorado Blvd., D-105
Pasadena, CA 91106 | (626) 585-7244

Telehealth Consent & Fees

Consent for Telehealth Services, Pricing & Lab Fees

I consent to receive TeleHealth services with the Student Health Services (SHS) staff and providers, which may require me to use electronic devices, such as a smartphone or desktop/laptop with a two-way webcam and audio capability before, during, and after my appointment takes place. I understand that there are inherent risks, benefits, and security limitations to using these e-visit formats, including unsecured privacy at my location, and I voluntarily assume them.

- I understand that Student Health Services will take all measures possible to keep all my information private and confidential, including encryption and a HIPAA-compliant platform.
- I have read and understand the information provided above.

Fees:

- I understand that there are fees associated with labs, prescriptions, or procedure fees for services obtained through PCC SHS and that I am financially responsible for those fees.
- I acknowledge that I will need to provide credit card information that will be manually entered into SHS's credit card machine and the signature on this form will be applicable to the receipt generated.
- I have the right to protect my credit card information and if I do not want to provide my credit card information, I will need to process any payments for fees through the PayPal payment portal I am referred to by an SHS staff member.

A staff member will discuss fees with you during your consultation prior to any labs, prescriptions, or procedure fees done or administered.

Health Science Students:
An administrative fee may be applicable depending on your enrollment status. This information will be provided to you prior to your first consultation with SHS.

Consent to Discuss/Release Test Results:

- I consent to have a SHS clinical team member contact me via electronic devices to discuss and review laboratory results.
- I will complete the Authorization to Release Health Information form to obtain a physical copy of my results via postal mail or fax and submit it to PCC SHS.

Signature:

- I authorize PCC SHS to charge my credit card for the payment of fees incurred by services provided by PCC SHS.
- I understand that my credit card information will not be saved to my student file for future transactions usage.

PRINTED NAME: _____ **SIGNATURE:** _____

LANCER ID: _____ **TELEPHONE:** _____ **DATE:** _____