Client Registration Form

(Please Print Clearly)

IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

NAME: _____
Last First M.I.

EMAIL: _____ **BIRTH DATE:** _____/_____/_____

SEX: ☐ Male ☐ Female ☐ TG **RACE/ETHNIC:** ☐ White ☐ African-Amer. ☐ Asian ☐ Hispanic/Latino ☐ Other

ADDRESS: _____
No. Street Apt. City State Zip

PHONE: ☐HOME ☐OFFICE ( ) _____-_____ **CELL:** ( ) _____-_____

OCCUPATION: _____ **EMPLOYER/SCHOOL:** _____

WORK/SCHOOL ADDRESS: _____

INSURANCE OR HEALTH COVERAGE: (CHECK ALL THAT APPLY): ☐ None

☐ Aetna ☐ CIGNA ☐ Medicare ☐ Brown & Toland
☐ Blue Shield ☐ Kaiser ☐ Healthy San Francisco ☐ Hill Physicians
☐ Blue Cross ☐ United Health ☐ Other _____

EMERGENCY CONTACT _____
Name Relationship Phone

PREFERRED LOCAL HOSPITAL IN CASE OF EMERGENCY: _____

HOW DID YOU LEARN ABOUT AITC: (CHECK ALL THAT APPLY) ☐ I am an established client of AITC

☐ Web Search ☐ Referred by my doctor/clinic (name, phone) _____
☐ Online Ad ☐ Referred by my school/employer (name) _____
☐ Newspaper Ad ☐ Referred by my friend/family/other (name) _____
☐ Muni Ad ☐ Yelp ☐ Other (describe)_____

Consent for Medical Care and Payment Responsibility

(1) I, as the client/patient, agree to receive care from a health care provider at the Adult Immunization & Travel Clinic ("AITC"), San Francisco Department of Public Health ("DPH"). I give consent for examination, immunization, blood or skin testing, medical advice, and other services from my AITC provider. (2) I understand that it is my responsibility to pay for services received. I understand that AITC does not bill insurance, and that it is my own responsibility to submit any required documents/paperwork to my insurer for reimbursement. (3) I acknowledge receipt of the DPH "Notice of Privacy Practices" (reverse side). I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the Notice. (4) I understand that DPH email transmission may not be secure against unauthorized disclosure, and I hereby authorize that DPH may send my health information to me via unsecure email, but only upon my specific request to receive such information by email.

Signed: _____ Date: _____

If client is a minor:

Print name of parent/ guardian: _____

Signature of parent/guardian: _____ Date: _____

SUMMARY DPH NOTICE OF HIPAA PRIVACY PRACTICES

The attached Notice describes how health information about you may be used and disclosed in the San Francisco Department of Public Health and your rights regarding the use of that information.

Please review this summary and the full Notice carefully.

DPH Pledge: Employees of the San Francisco Department of Public Health (DPH), its affiliates and contract providers understand that information about you and your health is personal. They are committed to protecting your health information.

Who will follow the rules in this notice: All DPH and contract provider employees, DPH affiliates, as well as staff assigned to DPH by the University of California at San Francisco, must follow these rules.

You have the right to: (please see possible restrictions starting on page 2 in the full Notice)

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes; for example, research.
- Ask DPH to send copies of your health record to whomever you wish (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment, and program improvement purposes).
- Specify where and how DPH employees may contact you.
- Receive a paper copy of the full DPH Notice of Privacy Practices.

DPH may use and disclose your health information to improve your treatment.

- To improve the quality of care you receive, your health information may be shared between treatment providers – including health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
- There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as when you receive services in a substance abuse treatment agency.
- See Page 4 in the "Notice of Privacy Practices" for more information. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or call the DPH Privacy Officer directly at (415) 206-2354.

If you believe your privacy rights have NOT been maintained while receiving DPH services, you may file a complaint with the DPH Privacy Officer at (415) 206-2354. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services' Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, SF, CA 94103. You will not be penalized in any way for filing a complaint.

By your signature on the reverse side of this page, you:

- acknowledge receipt of the San Francisco Department of Public Health "Notice of Privacy Practices." Your signature does not authorize disclosure, but only acknowledges that you have received a copy of the full Notice.

- acknowledge your understanding that DPH email does not provide secure data transmission as defined by HIPAA, that DPH email transmission may not be secure against unauthorized disclosure, and that DPH may send your health information to you via unsecure email, but only upon your specific request to receive such information by email.