

PLEASE PRINT CLEARLY

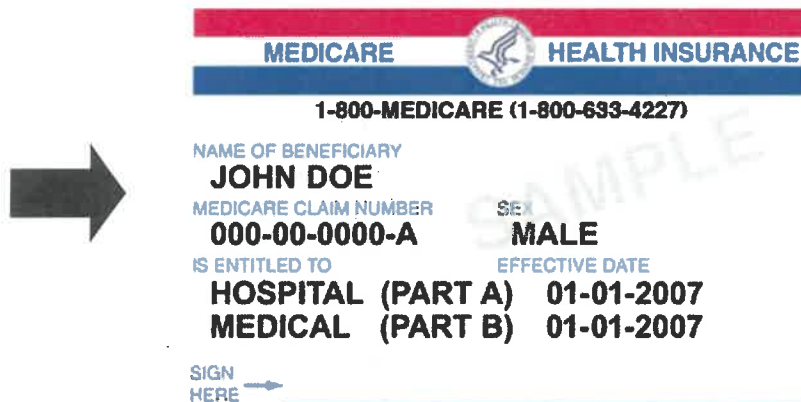
NAME _____

BIRTHDATE _____

SIGNATURE _____

TODAY'S DATE _____

**The Medicare card (federal government issued health insurance)
looks exactly like this**



PLEASE CHECK ONE:

- NO**, I am **NOT** enrolled in any type of Medicare Plan
- YES**, I have **Medicare** (read below)

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

FOR STAFF ONLY:

Contracts on file

TO OUR VALUED MEDICARE CLIENTS:

- Our Medical Director and Nurse Practitioner have “opted out” of Medicare
- To receive services at AITC, please sign and date both of the attached Private Contracts, one with our Medical Director and one with our Nurse Practitioner
- This contract is with AITC Immunization & Travel Clinic only. It does not affect your Medicare benefits anywhere else
- Unfortunately, if you do not sign a Private Contract with AITC, we will not be able to provide services to you

What signing the Private Contract means:

- To receive services at AITC, you must pay out-of-pocket at our listed prices, even if those services would be covered elsewhere by Medicare
- Medicare will not pay for any services received at AITC
- You agree not to submit a claim to Medicare
- AITC will not bill Medicare for you
- You are not required to sign a Private Contract with AITC. You are free to seek Medicare services elsewhere from a practitioner that has not opted-out

- THANK YOU FOR YOUR UNDERSTANDING

Client Registration Form

(Please Print Clearly)



Last Name

Grid for Last Name

First Name

Grid for First Name

M.I

Box for M.I.

Birthdate

MM DD YY grid

Race/Ethnicity

- White, African-Amer., Asian, Hispanic/Latino, Other

What was your sex at birth?

- Male, Female

What is your gender identity?

- Male, Female, Trans Male, Trans Female, Genderqueer / Gender non-binary, If Not Listed, please specify below

Email

Grid for Email

PHONE: CELL () - () HOME OFFICE : () -

ADDRESS: City State Zip

OCCUPATION: EMPLOYER/SCHOOL:

WORK/SCHOOL ADDRESS:

EMERGENCY CONTACT Name Relationship Phone

HOW DID YOU LEARN ABOUT AITC: (CHECK ALL THAT APPLY)

- I am an established client of AITC, Web Search, Yelp, Referral by my friend/family/school/ work, Other, Referral by my doctor/clinic (name, phone)

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) If my AITC Provider prescribes a drug, I understand that AITC can transmit the prescription to a pharmacy of my choice; or, if I purchase the drug from AITC, I understand that the drug is not returnable and that insurance may not reimburse the cost.
(3) I have reviewed the information about privacy practices and disclosures on the reverse side of this form.
(4) I understand that AITC is not a Medicare provider.
(5) I understand and agree that: (a) it is my responsibility to pay the charges in full for all services rendered; (b) I authorize my insurance company to pay directly to AITC any benefits due under the terms of my health care plan for services provided by AITC; (c) AITC reserves the right to refuse assignment of medical benefits; and (d) if my insurance company does not pay the charges in full, it is my responsibility to pay the entire full balance for all services rendered by AITC.

Signed: Date:

If client is a minor:

Print name of parent/ guardian:

Signature of parent/guardian: Date:

SFDPH SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES

Full Notice: You have been provided the Full Notice of HIPAA Privacy Practices. Please read it carefully. You can also find it at: <https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/HIPAAsummaries.asp>.

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 in the "Full Notice of Privacy Practices".)

- 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 that copies of your health record be sent to someone (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.

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

- To improve the quality of care you receive, health information may be shared between treatment providers, including your 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 services received in substance abuse treatment agencies.

If you believe your privacy rights have NOT been maintained while receiving DPH services, you may file a complaint. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or contact either of the following: (1) Secretary of U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. (2) DPH Office of Compliance and Privacy Affairs, 101 Grove St., Room 330, San Francisco, CA 94102, or call toll-free 1-855-729-6040. 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 "Full Notice of HIPAA Privacy Practices."
- Agree that if the DPH services you received at AITC are to be billed to a third party health insurance, then you authorize the release to the insurer, the claims processor, and their intermediaries, of any medical and other information necessary to process the claim.

NAME: _____

BIRTHDATE: _____

TELL US THE REASON(S) FOR YOUR TB SCREENING TODAY (CHECK ALL THAT APPLY)

- I need a TB test for work or school. (employer or school): _____
- Other reason: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Yes No **Were you born or raised outside the USA?**
 If Yes ⇒ Country of Birth _____
 Year entered the USA _____
 Received BCG* vaccine? Yes No
 Year of last BCG _____ N/A

* BCG = a TB vaccine given in some countries (but not in the USA)

Date of Most Recent TB Test
 day / mo / yr Type of test Skin test
 Never had Blood (Quantiferon)
 Don't know

Yes No **Ever had a Positive** TB test?**
 If Yes ⇒ Year of Positive TB test _____
 Type of test Skin test
 Blood (Quantiferon)

** Positive TB Skin Test = Raised bump at test site; told by health care professional it was TB positive, usually requires a Chest X-Ray.

Yes No **Ever had a Chest X-Ray for TB?**
 If Yes ⇒ Year of Chest X-Ray _____
 Result Active TB
 Not Active TB

Yes No **Ever taken INH (Isoniazid) for TB?**
 If Yes ⇒ Year you took INH _____
 Number of months taken _____

I certify that the information I have provided is true to the best of my knowledge. I will not hold this clinic or its staff responsible for any errors or omissions I may have made in completing this form.

Client Signature _____ **Date** _____

Yes No **Take any medications?**
 If yes, list: _____

Yes No **Have any medical conditions?**
 If yes, list: _____

Yes No **Have a condition or take a medicine that weakens the immune system?**

Yes No **Currently pregnant?**

Yes No **Faint or get lightheaded with needles?**

Yes No **Allergic to medications or vaccines?**
 If yes, list: _____

Have you ever:

Yes No **Been sick with, or treated for TB?**

Yes No **Had contact with, or lived with someone sick with active TB?**

Yes No **Lived or worked in a refugee camp, homeless shelter or jail?**

Yes No **Been a health care worker?**

Yes No **Traveled to the developing world and had close contact with the local population? If yes, describe:** _____

Do you have these symptoms?

Yes No **Cough lasting more than 3 weeks?**

Yes No **Coughing up blood?**

Yes No **Unintentional weight loss?**

Yes No **Loss of appetite?**

Yes No **Fever?**

Yes No **Sweating at night?**

AITC STAFF USE ONLY

TEST: 1-Step TST 2-Step TST QFT-IT Gold Symptom Review Only (skip to p. 2) →

Step	Date Placed	Site	Lot #	Placed By	Date Read	Result	Read By
#1	_____	R L	_____	_____	_____	_____ mm	_____
#2	_____	R L	_____	_____	_____	_____ mm	_____

ASSESSMENT: Pos Neg State TB Risk Assessment
 Yes No AITC TB Risk Factor(s)
 Yes No AITC TB Symptoms
 Pos Neg Ind TST Step #1
 Pos Neg TST Step #2
 Pos Neg Ind QFT-IT Gold

PLAN: State Certificate Completed Yellow Card w/Result TB-47 Given
 CXR Referral Form Education per Protocol
 Other Referral To: _____ For: _____

Clinician Signature: _____ Date: _____

History of LTBI

⇒ **AITC STAFF USE ONLY**

TB Testing (list dates, test types, findings) _____

CXR (list dates, findings, esp. most recent CXR) _____

Sx Review Positive for Sx Negative for Sx

LTBI Tx Treated: Completion Documented → *(Attach Copy of Documentation)*
 Incomplete: Not completed, Not Documented, or Documentation Unavailable
 Not Treated

Congregate Yes No Employee or resident of Congregate Living setting (jail, shelter, SNF, rehab, etc)

Exposure Yes No Recent (since last TB eval) exposure to Active TB Case

Risk Factors Yes No HIV or other significant immune compromise due to illness or medication
 Yes No TB test conversion within past 2 years
 Yes No On immune modulator therapy for autoimmune disease
 Yes No End Stage Renal Disease, silicosis, jejuno-ileal bypass, or head/neck carcinoma
 Yes No Old inactive TB on prior CXR
 Yes No Diabetes, gastrectomy, IV drug use, or malnutrition

DISPOSITION / PLAN

- (A)** No F/U needed unless new TB exposure or Sx develop
- (B)** Return annually for Sx Review — get CXR whenever symptomatic
- (C)** CXR / PCP Visit now to evaluate for TB reactivation. (If NEG, return for annual Sx review.)
- (D)** CXR now to evaluate for TB reactivation; Plus Sx Review every 3 mos, CXR every 6 mos
- (E)** CXR now to evaluate for TB reactivation; Plus CXR & Sx Review every 6 mos x 2 years
- (F)** CXR now to evaluate for TB reactivation; Plus Sx Review every 6 mos, CXR annually
- (G)** CXR now to evaluate for TB reactivation; Plus CXR & Sx Review annually

Referral To: _____

Clinician Signature: _____ Date: _____