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).
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)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>M.I.</th>
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<tr>
<th>First Name</th>
<th>M.I.</th>
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<tr>
<th>Birthdate</th>
<th>_race/ethnicity</th>
<th>What was your sex at birth?</th>
<th>What is your gender identity?</th>
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<tbody>
<tr>
<td>H M D Y</td>
<td></td>
<td>Male</td>
<td>Female</td>
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<tr>
<th>Email</th>
<th>PHONE:CELL:</th>
<th>HOME:OFFICE:</th>
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<tr>
<th>ADDRESS:</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>OCCUPATION:</th>
<th>EMPLOYER/SCHOOL:</th>
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<th>WORK/SCHOOL ADDRESS:</th>
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<tr>
<th>EMERGENCY CONTACT</th>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<th>HOW DID YOU LEARN ABOUT AITC: (CHECK ALL THAT APPLY)</th>
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<tbody>
<tr>
<td>I am an established client of AITC</td>
</tr>
<tr>
<td>Referral by my doctor/clinic (name, phone)</td>
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</table>

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/HIPAA_Summary.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.
**TB SCREENING FORM**

**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  **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**  **Blood (Quantiferon)**

- **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?  

**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**

**AITC STAFF USE ONLY**

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<thead>
<tr>
<th>TEST</th>
<th>Date Placed</th>
<th>Site</th>
<th>Lot #</th>
<th>Placed By</th>
<th>Date Read</th>
<th>Result</th>
<th>Read By</th>
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<tbody>
<tr>
<td>1-Step TST</td>
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<td>2-Step TST</td>
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<tr>
<td>QFT-IT Gold</td>
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**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**  **Ind**  TST Step #2
- **Pos**  **Neg**  **Ind**  QFT-IT Gold

**PLAN:**

- **State Certificate Completed**
- **Yellow Card w/Result**
- **TB-17 Given**

**Other Referral To:**  

**For:**

**Clinician Signature:**

**Date:**

12 Feb 2015
### TB Screening Form - Continued

#### History of LTBI

**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, jejun-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: __________________________