aitc IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

Adult Immunization & Travel Clinic
101 Grove Street, Room 102
San Francisco, CA 94102
ph (415) 554-2625 fx (415) 554-2619
www.sfdph.org/aitc

PLEASE PRINT CLEARLY

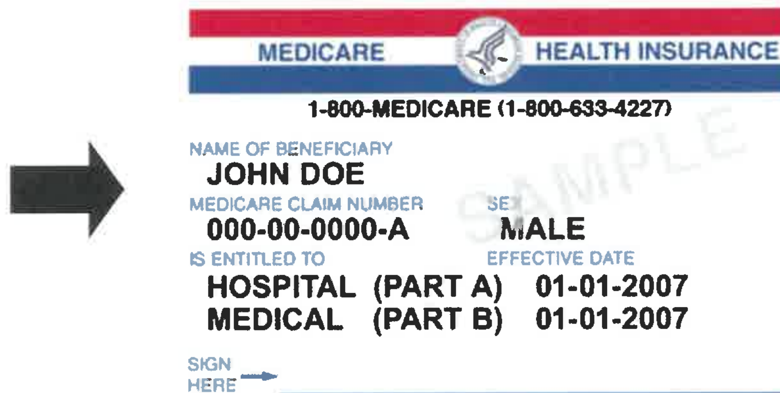
NAME ______________________________

BIRTHDATE ______________________________

SIGNATURE ______________________________

TODAY'S DATE ______________________________

The Medicare card (federal government issued health insurance) <u>looks exactly like this</u>



PLESE CHECK ONE:

☐ **NO**, I am **<u>NOT</u>** enrolled in any type of Medicare Plan

☐ **YES**, <u>I have Medicare</u> (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).

<u>FOR STAFF ONLY:</u>
☐ 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

Patient Registration Form

(Please Print Clearly)

Legal Last Name

Legal First Name **M.I**

☐ I have a different legal name ____________________________

Birthdate

M M / D D / Y Y Y Y

Legal sex

☐ Male ☐ Female
☐ Unknown ☐ Nonbinary
☐ Other __________

MAILING ADDRESS ____

APT# City State Zip

PHONE: CELL ( ) ________-__________ ☐HOME ☐OFFICE : ( ) ________-__________

EMAIL ADDRESS

NEED INTERPRETER: YES / NO

PREFERRED LANGUAGE: ____________________

RACE

☐ African-Amer.
☐ American Indian (Native)
☐ Asian
☐ Other
☐ Pacific Islander
☐ White

HISPANIC/LATINO?

☐ Yes
☐ No
☐ Decline to Answer

RECOMMENDED AND REQUIRED FOR ALL MINORS

EMERGENCY CONTACT ____

Name Relationship Phone

San Francisco Department of Public Health

SFDPH Summary Notice of HIPAA Privacy Practices and Acknowledgement of Receipt

DOB	
MRN	
PCP	
Patient ID / Addressograph	

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.

I Understand. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I acknowledge receipt of the SF Department of Public Health "Full Notice of HIPAA Privacy Practices."

SIGNATURE OF PATIENT/RESIDENT/CLIENT OR THEIR REPRESENTATIVE		DATE
PRINT NAME	IF REPRESENTATIVE, SPECIFY RELATIONSHIP	INTERPRETER IF APPLICABLE

STAFF/WITNESS: If written acknowledgement is NOT obtained, please complete the following:

☐ Unable to sign ☐ Declined to sign ☐ Other, Describe:	
SIGNATURE OF STAFF WITNESS	DATE
PRINT NAME	DEPARTMENT/ORG

San Francisco Health Network ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER SAN FRANCISCO HEALTH NETWORK PRIMARY CARE	NAME DOB MRN PCP Patient ID / Addressograph

TERMS AND CONDITIONS OF ADMISSION FOR ACUTE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

CERTIFICATION

I hereby certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise duly authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: ______________________________ Time: ____________________ AM/PM

Signature: ____
Patient or Legal Representative

Print Name: ____
Patient or Legal Representative

☐ Refused to Sign ☐ Physically Unable to Sign

If signed by someone other than the patient, indicate

relationship: ______________________ and Date of Birth ______________________

Witness: ________ / ________ / ______________________ / ______________________
Date Time Print Name Signature/Title

Witness: ________ / ________ / ______________________ / ______________________
Date Time Print Name Signature/Title

Interpreter: ________ / ________ / ________________ / ________________ / ____________
Date Time Print Name Signature (if present) Interpreter ID#

Advance Directives: SFHN honors patients' wishes regarding treatment decisions whenever possible. SFHN encourages individuals to communicate their health care preferences to their health care providers and to those who may have to make health care decisions for them if they become incapacitated. SFHN does not discriminate against an individual based on whether or not the individual has executed an Advance Directive. If an Advance Directive has been executed, the undersigned is responsible for providing a copy of the Advance Directive to SFHN for inclusion in the medical record.

Do you have an Advance Directive for Health Care? ☐ Yes ☐ No

☐ I have been informed that it is my responsibility to present this Directive to the SFHN as a permanent part of the chart.

☐ I have received information on Advance Directives.

☐ I decline to receive information on Advance Directives at this time.

UPON REQUEST, A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND THE SIGNATOR.

T-AD0014

NAME

DOB

MRN

PCP

Patient ID / Addressograph

San Francisco Health Network

ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER
LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER
SAN FRANCISCO HEALTH NETWORK PRIMARY CARE

TERMS AND CONDITIONS OF ADMISSION FOR ACUTE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

I. GENERAL CONSENT

A. Consent to Medical and Surgical Procedures: I consent to the procedures which may be performed during this hospitalization or while I'm an outpatient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, care facilitated by telecommunication technologies ("telehealth"), anesthesia, or hospital services provided to me under the general and special instruction of a physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment.
Maternity Patients: If I deliver an infant(s) while a patient of this hospital, I agree that these same conditions of admission apply to the infant(s).

B. Photography/Videotaping: I consent to the taking of pictures, videotapes and recordings necessary for identification purposes, to document processes of diagnosis and treatment and to document injuries sustained in trauma. I further consent to the use of such pictures, videotapes and recordings for provision of care, quality improvement, education, and reimbursement purposes.

C. Teaching, Research and Healthcare Institution: Zuckerberg San Francisco General Hospital, Laguna Honda Hospital and affiliated clinics are a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees and visiting professors may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of the medical education programs. I also understand that an institutional review board approves projects conducted by the researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

D. Use of Medical Information and Specimens: I understand that my medical information, photographs, and/or video in any form may be used for other Department of Public Health (DPH) purposes, such as quality improvement, patient safety and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that the DPH may collect during the course of my treatment and care may be used and shared with researchers and any such use will be in accordance with state and federal law, including all laws and regulations governing patient confidentiality, in the manner outlined in the Notice of Privacy Practice. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research.

TERMS AND CONDITIONS OF ADMISSION FOR ACUTE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

I understand that if I am diagnosed with a reportable disease in California, including but not limited to cancer, HIV, sexually transmitted diseases, seizures, tuberculosis, viral meningitis, or other reportable diagnosing, DPH is required by law to report my diagnosis to governmental organizations such as the State Department of Health Services or the Center for Disease Control and Prevention. DPH is also required by law to report immunizations and TB tests will be reported to the California Immunization Registry as required by law. If you do not want this information shared with other providers you can contact the CAIR registry cairweb.org or help desk 1-888-436-8320

E. Medication History: I consent that DPH may electronically access my medication history from external pharmacies and record this information in my medical record unless I provide DPH with timely written notice of my objection. I understand that the DPH may use software to search the computer databases of external pharmacies and pharmacy benefit managers for purposes of obtaining my medication history and making decision regarding my care.

F. Body Substance Precautions: I understand that DPH health care workers are required to follow strict Body Substance Precautions in all patient care activities to protect both patients and staff from infections. Therefore, health care workers are not required to be tested for bloodborne pathogens.

G. E-mail and Texting Consent: I consent to having appointment reminders sent to me via texting/email or MyChart notification with the understanding that I may opt out at any time. I understand that if I email or text physicians and others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and email by either sender are not secure communication methods as unencrypted messages could be intercepted.

H. Health Information Exchange: I consent to having my information available via a secure network such as Epic CareEverywhere, with understanding that I may opt out at any time. This exchange allows authorized health care providers/organizations and professionals involved in your treatment, coordination of care, quality improvement and activities related to management or payment of your healthcare access to your health records quickly to provide you with the appropriate medical treatment and related services.

I. Care Coordination: I consent to the disclosure and use of my health information by providers with DPH and between DPH, its affiliates and contract providers for the purposes of care coordination. The health information shared may include but is not limited to: dental, vision, hearing, nutrition, tobacco cessation, labwork, development, and mental health that may be necessary for my treatment.

NAME

DOB

MRN

PCP

Patient ID / Addressograph

TERMS AND CONDITIONS OF ADMISSION FOR ACUTE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

H. Lien Against Third Parties: In the event that I file a cause of action in a court or assert a claim against another party alleging that any part of the hospitalization or outpatient services were necessitated by the wrongful conduct of another, I agree to give notice of such case to the Bureau of Delinquent Revenue Collection in the Tax Collector Office as provided in San Francisco Health Code Section 124.5 to facilitate enforcement of the cost reimbursement lien established by San Francisco Health Code Section 124. I acknowledge that the cost of service under the circumstances stated herein is a lien upon any damages recovered by me, whether by judgment, settlement, or compromise.

I. Health Plan Obligation: DPH maintains a list of health care service plans with which it contracts. A list of such plans is available upon request from the financial office. DPH has no contract, express or implied, with any plan that does not appear on the list. I agree to pay the full charges of all services rendered to me by DPH if I belong to a plan that does not appear on the above mentioned list. Physicians and surgeons may bill separately for their services. It is my responsibility to determine if physicians providing services to me contract with my health plan, if any.

IV. TERMS FOR INPATIENTS ONLY

A. Provider Orders: I agree that medical treatments administered in the hospital will be limited to those prescribed by a provider or surgeon who is a member of the hospital Medical Staff.

B. Nursing Care: The hospital provides only general nursing care and care ordered by the physician members of the medical staff. If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

C. Remain On Nursing Unit: I agree to remain in the unit/hospital. I understand that if I make the choice to leave the unit/hospital unaccompanied by hospital staff, without the permission of nursing staff or physician orders, that I may be discharged from the hospital.

D. Personal Valuables: Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500.00) unless I receive a written receipt for a greater amount from the hospital. Clothing and other personal items will be discarded if not claimed within thirty (30) days of discharge from the hospital.

TERMS AND CONDITIONS OF ADMISSION FOR ACUTE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

J. Privacy - Social Security Number: Pursuant to the Federal Privacy Act of 1974, you are hereby notified that if you have a social security number, disclosure of your social security number is mandatory. It is used to verify your identity in the medical care, and payment system. Disclosure of the social security number is required pursuant to regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II, of the Social Security Act, as amended.

II. STANDARDS OF CONDUCT

A. DPH Policies: I agree to abide by all DPH policies regarding my conduct on DPH premises.

B. Smoke Free Environment: I acknowledge that DPH is a smoke free environment and agree not to smoke inside any of its buildings or on DPH premises.

C. Safe Environment for Patient Care: No Alcoholic Beverages, Illegal Drugs, or Fire Arms: I agree not to bring alcoholic beverages, illegal drugs, firearms or other dangerous weapons onto DPH premises. I agree that my personal belongings may be searched by properly authorized personnel of DPH, the San Francisco Police Department or the San Francisco Sheriff's Department.

III. FINANCIAL TERMS

A. Agreement to Reimburse DPH: I agree to pay the full costs of health care services as provided by applicable federal and state laws, ordinances, resolutions, and orders of the City and County of San Francisco including, but not limited to, San Francisco Municipal Code Part III, Chapter V. Article 3 (Health Code). I agree to permit DPH to investigate and verify any personal and/or financial information submitted in support of my request for services and any application for public entitlement benefits. I hereby freely and voluntarily waive the statute of limitation of DPH's right to assert a lien against my property or commence in any action in the courts of the State of California to collect the costs of hospital care, outpatient services and professional services. I understand that I will receive messages and calls on behalf of DPH, at the numbers provided, including my cell phone number and e-mail address provided during my registration process. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I authorize DPH to execute all refunds resulting from any charges incurred by me or persons for whom I am the responsible party.

B. Relationship Between DPH and UCSF Physicians at Zuckerberg San Francisco General Hospital: I understand that the physicians and surgeons at Zuckerberg San Francisco General Hospital, in both the inpatient and outpatient setting and including radiologists, pathologists, emergency physicians, Anesthesiologists, and others, are not employees or agents of the hospital or DPH. These physicians may bill separately for professional services under the business name the San Francisco Medical Group.

TERMS AND CONDITIONS OF ADMISSION FOR ACUTE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

C. **Agreement to Reimburse San Francisco Medical Group:** I agree that in consideration of the services provided by any physician, surgeon or dentist at Zuckerberg San Francisco General Hospital that I will pay the regular rates for all professional fees for which I am liable. I agree to permit the San Francisco Medical Group to investigate and verify any personal and financial information submitted in support of the request for admission or outpatient services and for any application for public entitlement benefits. I hereby freely and voluntarily waive the statute of limitation of the San Francisco Medical Group's right to assert a lien against my property or commence in any action in the courts of the State of California to collect the costs of professional services.

D. **Release of Information for Reimbursement:** I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, DPH may disclose portions of my medical record to any person or corporation which is, or may be, liable for all or any portion of DPH's charges, including, but not limited to, insurance companies, insurance carrier's review organizations, health care service plans, or workers' compensation carriers. I understand that my medical record may be reviewed by a contractor or representative of such a person or corporation. I also understand that in order for me to prevent the release of my medical record for reimbursement purposes, I must provide DPH with timely written notice.

E. **Assignment of Benefits:** I assign and authorize direct payment to DPH and the San Francisco Medical Group for all insurance benefits payable for this hospitalization or for these outpatient services. I agree that the insurance company's payment pursuant to this authorization shall discharge the insurance company's obligation to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment.

F. **Medi-Cal/Medicare Parts A & B:** I certify that any information given in applying for benefits of the MEDI-CAL or MEDICARE programs is correct. I authorize release of any information necessary to act on this application. I request that payment of any benefits be made on my behalf to DPH and the San Francisco Medical Group and agree to pay any remaining charges for which I am legally responsible.

G. **Authorized Representative:** I authorize DPH, at its election but without obligation, to represent me regarding any application and appeal for eligibility and benefits related to Medicare, MEDI-CAL, California Children Services, Victims of Crimes, or other programs providing benefits relating to services rendered at a DPH facility.