Client Registration Form

(Please Print Clearly)

IMMUNIZATION & TRAVEL CLINIC
SF DEPARTMENT OF PUBLIC HEALTH

Last Name

First Name **M.I**

Birthdate (M M D D Y Y)

Gender ☐ Male ☐ Female ☐ TG

Race/Ethnic ☐ White ☐ African-Amer. ☐ Asian ☐ Hispanic/Latino ☐ Other

Email

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

ADDRESS: _____
City State Zip

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

WORK/SCHOOL ADDRESS: _____

EMERGENCY CONTACT _____
Name Relationship Phone

COMPLETE THIS SECTION ONLY IF AITC WILL BILL YOUR INSURANCE (BLUE SHIELD OF CALIFORNIA PPO ONLY)

SOCIAL SECURITY # :

EMAIL TO NOTIFY YOU OF ANY CREDIT CARD CHARGES FOR THE BALANCE (IF DIFFERENT FROM ABOVE):
☐ Same Email as Above

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.