ACKNOWLEDGEMENT OF CONTACT INFORMATION DISCLOSURE / FINANCIAL RESPONSIBILITY STATEMENT / CONSENT FOR TREATMENT

How we may use your protected health information:

We will only use your personal information, including your name, date of birth, address, phone number, and social security number (if you have one) to treat you, prescribe medication for you, refer you to other providers, or to sign you up for certain State programs to help pay for your visit.

We will not and cannot share your information (without your written permission) with anyone else except under the following treatment-related circumstances:

- If you receive a positive result on certain sexually transmitted infection (STI) tests, namely Gonorrhea, Chlamydia, Syphilis, or Viral Hepatitis, we are required by law to disclose your information to the San Francisco Department of Public Health (SFDPH). If we cannot reach you, and you do not receive treatment for one of these infections, a representative from SFDPH may contact you at home or at work.

- If we refer you directly to another provider for care, we may release your relevant medical records to them without obtaining another signature from you. If you wish to have records sent to your provider without a referral from us, we are required to get a signature from you stating to whom you wish to have your records sent, and which records you wish to have sent.

- We ask for your permission to send mail to your address. This mail may include information about your health. If you do NOT want to receive mail at this address, please be sure to provide us with other ways to contact you, including phone numbers and email addresses. If you have an alternate address, such as work or a friend, please leave us that address. ***If you receive abnormal lab results or we need to follow-up about a health matter and we cannot reach you by phone or email to discuss them, we may still send a letter to your street address indicating that we need for you to contact us. We may do this even if you indicate that you do not want to receive mail about your health information.***

- Please select someone for your emergency contact whom we may call or send mail to if we need to reach you about test results. If your results require urgent attention, we must make every attempt possible to notify you about them including trying to reach you through your emergency contact.

We will not deny you services if you do not provide us with your contact information, or if you do not have any contact information, but we do encourage you to help us give you the best healthcare possible by giving us current information about how to contact you by phone, email, and postal mail.

Our payment policy:

We are committed to providing personalized, high quality health care to our clients in the most cost-effective manner. As part of our professional relationship it is important that you understand our financial policy.

<u>Client Responsibility</u>
It is your responsibility to contact Women's Community Clinic whenever your income or household status changes.

<u>Standard Payment Policy</u>

Payment for services is due at the time services are rendered. We can provide you with an itemization of charges. For your convenience we accept cash, checks, VISA and Mastercard.

Returned Checks: A service fee of $35.00 is charged on all returned checks. Returned checks must be recovered within 10 days or the client may be denied future services from this clinic. If a check is returned for non-sufficient funds more than once by a client then payment will only be accepted by cash or credit card.

Family PACT Clients

- For FPACT enrolled clients, you must present your FPACT card at time of registration.
- Clients may apply to enroll in FPACT when at the Clinic.
- Clients are responsible for all charges that FPACT does not cover.

Medi-Cal Clients

- Medi-Cal/San Francisco Health Plan clients must present your card and ID at time of registration.
- Clients are responsible for all charges that Medi-Cal does not cover.

We are committed to providing quality care to all clients, regardless of ability to pay. If you feel that you cannot afford our services, please ask to speak with a supervisor so that we can assist you in accessing care.

Acknowledgements and consents:

I have read and understand the above and agree to comply with the financial policies of the Women's Community Clinic.

I understand that it is important for me to give the Women's Community Clinic as many ways to contact me as possible. I will keep the Women's Community Clinic informed of changes in my address, telephone number, and email address. In the event that staff of the Women's Community Clinic cannot reach me by phone or email to notify me about urgent and/or abnormal test results or follow-up, I understand that I may receive mail at my street address from the Women's Community Clinic. If I have asked NOT to receive mail about my health information, the mail I receive will only indicate that I should contact the Clinic as soon as possible. I understand that the Women's Community Clinic makes this effort to reach patients only to ensure they receive the best possible healthcare, and the Clinic is legally obligated to exhaust all methods to reach patients to notify them of abnormal lab results.

I give my permission to be treated by the Women's Community Clinic and I understand that I can withdraw my consent at any time.

Name: Signature: Date:

For primary care clients age 17 and under, parent/guardian to complete:

I give my permission for _____ (fill in name) to be treated by the Women's Community Clinic and I understand that I can withdraw my consent at any time.

Name: Signature: Date: