



PATIENT REGISTRATION FORM

CONFIDENTIAL

Personal Contact Information

Last Name: _____ First Name: _____ Date of Birth: ____/____/____

Address (Street & Apartment # or PO Box): _____

City: _____ State: _____ Zip: _____ Can we send mail regarding your health information here?
Yes No

Email Address: _____

If you don't have a fixed address, where do you currently live or hang out? How can we contact you there?

Primary Phone Number: (____) _____
Can we contact you here? Yes No
If YES, should we identify ourselves as Women's Community
Clinic or "Lulu"? Clinic Lulu
Can we leave a detailed message? Yes No

Alternate Phone Number: (____) _____
Can we contact you here? Yes No
If YES, should we identify ourselves as Women's Community
Clinic or "Lulu"? Clinic Lulu
Can we leave a detailed message? Yes No

UPDATE of Personal Contact Information (Date Updated: _____)

Address (Street & Apartment # or PO Box): _____

City: _____ State: _____ Zip: _____ Can we send mail here? Yes No

Primary Phone #: _____ Alternate Phone #: _____ Email: _____

Race		How did you hear about us?		Sexual Orientation
1 African-American/Black <input type="checkbox"/>	10 Middle Eastern <input type="checkbox"/>	1 Friend/Relative <input type="checkbox"/>	2 Other Clinic <input type="checkbox"/> 8 USF <input type="checkbox"/> 3 Other School/College <input type="checkbox"/> 4 Internet <input type="checkbox"/> 5 Yellow Pages <input type="checkbox"/> 6 Outreach Worker <input type="checkbox"/> From where: _____ (note for data entry – 9 if the Clinic) 7 Other <input type="checkbox"/> Where: _____	1 Heterosexual <input type="checkbox"/>
3 Cambodian <input type="checkbox"/>	11 Native American <input type="checkbox"/>	2 Other Clinic <input type="checkbox"/>		2 Bisexual <input type="checkbox"/>
19 Chinese <input type="checkbox"/>	12 Pacific Islander <input type="checkbox"/>	8 USF <input type="checkbox"/>		3 Lesbian <input type="checkbox"/>
5 Filipina <input type="checkbox"/>	13 Russian <input type="checkbox"/>	3 Other School/College <input type="checkbox"/>		4 _____ <input type="checkbox"/>
6 Japanese <input type="checkbox"/>	14 Vietnamese <input type="checkbox"/>	4 Internet <input type="checkbox"/>		Gender Identity
7 Korean <input type="checkbox"/>	15 White/Caucasian <input type="checkbox"/>	5 Yellow Pages <input type="checkbox"/>		1 Female <input type="checkbox"/>
8 Laotian <input type="checkbox"/>	16 Multi-Ethnic <input type="checkbox"/>	6 Outreach Worker <input type="checkbox"/>		2 Transgender <input type="checkbox"/>
9 Latina /Hispanic <input type="checkbox"/>	17 Other <input type="checkbox"/>	7 Other <input type="checkbox"/>	3 Intersex <input type="checkbox"/>	
Weekly Income (before taxes) _____				4 _____ <input type="checkbox"/>
Ethnicity	Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/>	Primary Language _____		
Marital Status	Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Other _____			

Emergency Contact Information

Please give the name and contact information for someone who does not live with you, and whom we may contact if we cannot reach you about your health information:

Name: _____ Relationship to you: _____ Phone #: _____

Consent For Treatment And Use of Protected Health Information

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. I also understand that it is my responsibility to notify the Women's Community Clinic of any change in my contact information as listed above. Additionally, I consent to the use of my protected health information for the purpose of treatment, payment or operations at the Women's Community Clinic.

Signature: _____

Date: _____

CONSENT FOR TREATMENT / ACKNOWLEDGEMENT OF CONTACT INFORMATION DISCLOSURE**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.

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.

Signature: _____

Date: _____

HEALTH ACCESS PROGRAMS FAMILY PACT PROGRAM CLIENT ELIGIBILITY CERTIFICATION (CEC)

Client identification number

This form is the property of the State of California, California Department of Public Health, Office of Family Planning, and cannot be changed or altered.

Please **print** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you are eligible for Family PACT Program services.

- Providers must keep a copy of this form in the client's medical record. (See PPBI, Client Eligibility Certification Form Completion Section for code determinations.)
- **Code areas are for Provider use only.**

Do you currently receive Medi-Cal benefits or services? Yes No

Do you have a Medi-Cal Benefits Identification Card (BIC)? Yes No

BIC number	Issue date
------------	------------

Do you have health care insurance for family planning services? (Private insurance, Health Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.) Yes No

Do we need to keep your family planning services confidential from your partner, spouse, or parent? How may we contact you if we need to talk to you about something? Yes No
Confidentiality

Provider Use Only—CODE

First name	Middle name	Last name	Suffix (Jr., Sr.)
------------	-------------	-----------	-------------------

Is your current name the same as your name at birth? If no, print your name at birth below. Yes No

First name at birth	Middle name at birth	Last name at birth	Suffix (Jr., Sr.)
---------------------	----------------------	--------------------	-------------------

Number of live births	County of residence	Provider Use Only—CODE	Nine-digit ZIP code
-----------------------	---------------------	-------------------------------	---------------------

Gender	Provider Use Only—CODE	Social security number	Mother's first name
--------	-------------------------------	------------------------	---------------------

Date of birth (mm/dd/yyyy) / / _ _ _ _	Place of birth (county, if California)	Provider Use Only—CODE	State (if not California)	Provider Use Only—CODE	Country (if not USA)	Provider Use Only—CODE
---	--	-------------------------------	---------------------------	-------------------------------	----------------------	-------------------------------

Race/ethnicity

1 <input type="checkbox"/> Asian	2 <input type="checkbox"/> Black	3 <input type="checkbox"/> Filipino	4 <input type="checkbox"/> Hispanic
5 <input type="checkbox"/> Native American	6 <input type="checkbox"/> Pacific Islander	7 <input type="checkbox"/> White	0 <input type="checkbox"/> Other


Primary Language

1 <input type="checkbox"/> Armenian	2 <input type="checkbox"/> Cantonese	3 <input type="checkbox"/> English	4 <input type="checkbox"/> Hmong	5 <input type="checkbox"/> Khmer/Cambodian
6 <input type="checkbox"/> Korean	7 <input type="checkbox"/> Tagalog	8 <input type="checkbox"/> Spanish	9 <input type="checkbox"/> Vietnamese	0 <input type="checkbox"/> Other

This information will be used to see if you are enrolled in any state health program. Information will also be used to monitor health outcomes and for program evaluation purposes. Your name will not be shared. Each individual has the right to review personal information maintained by the provider unless exempt under Article 8 of the Information Practices Act.

Complete eligibility information on reverse side.

Eligibility Determination: Please list all family members (self, spouse, and children) living in your household and supported by the family income. List the source of any earned or unearned income and the amount of income, including income from employment, self-employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc.

Name	Relationship to You	Age	Source of Income	Gross Monthly Income (Before taxes or deductions.)
	(Self)			
Family size:			Total family income	\$

I declare under penalty of perjury that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for this program.

Signature (or mark) of applicant	Date	Signature of witness to mark or interpreter	Date
----------------------------------	------	---	------

FOR PROVIDER USE ONLY

Provider certification: Eligible for Family PACT Program
 Ineligible for Family PACT Program (Give applicant Fair Hearing Rights.)

Medi-Cal client eligible for Family PACT verified: Limited scope Unmet share-of-cost

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Client Eligibility Certification is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights.

Print name	Signature	Date
Annual Certification: If client is decertified (no longer eligible)		Date
		Reason code (see Provider Manual)

Fair Hearing Rights

Any applicant for, or recipient of, services under the Family PACT Program has a right to a hearing conducted by the California Department of Public Health regarding eligibility or receipt of services. An applicant or recipient does not have a right to contest changes made to the eligibility standards or benefits of the Family PACT Program.

First level review: If you wish to appeal either your denial of eligibility or receipt of services, please send your name, telephone number, address, and reason why you are requesting a review to the **First Level Review address** below. A request for a first level review must be postmarked within 20 working days of the denial of eligibility or services. The Office of Family Planning may request additional information by telephone or in writing from the provider or the applicant before issuing a decision.

Formal hearing: You may appeal the decision of the first level review within five working days of your receipt of the decision of the first level review by sending your name, telephone number, address, and reason for the appeal to the **Formal Hearing address** below. At the hearing, you may be represented by a friend, relative, lawyer, or other person of your choice. A representative of the provider will be present to explain the reasons for denying eligibility. If you want an interpreter provided at the hearing, please specify the language in your letter requesting a hearing.

First Level Review

California Department of Public Health
 Office of Family Planning
 MS 8400
 P.O. Box 997420
 Sacramento, CA 95899-7420

Formal Hearing

California Department of Public Health
 Office of Regulations and Hearings
 MS 0507
 P.O. Box 997377
 Sacramento, CA 95899-7377

FAMILY PACT RIGHTS

FAMILY PLANNING PATIENT RIGHTS

Men and women, regardless of race, religion, age, sex, sexual orientation, ethnic and religious background or economic standing have:

- The right to decide whether or not to have children and, if so, to determine their timing and spacing;
- The right to be treated with dignity and respect;
- The right to privacy and confidentiality in all aspects of services;
- The right to adequate and objective education and counseling;
- The right to have all procedures explained and questions answered in language that can be understood;
- The right to know effectiveness, possible side effects, and complications of all contraceptives;
- The right to participate in selecting the contraceptive method(s) to be used;
- The right to know the results and meanings (diagnosis, treatment, prognosis) of all tests and examinations;
- The right to see their records and have them explained;
- The right to know the meaning and implications of all forms they are asked to sign;
- The right to consent to or refuse any contraceptive method, test, examination or treatment.

Participation of any individual in the Family PACT Program is voluntary and free of compulsion or coercion of any kind. If you feel your rights have been violated, please speak to the director of the clinic/health office.

California Department of Health Services, 2001



womens
community
clinic

To: Our Clients

From: The Women's Community Clinic

Subject: Domestic Violence Screening

Because violence is becoming more recognized as a serious health problem among women in our community, our clinicians have begun to routinely ask clients about possible violence in their lives.

The Women's Community Clinic is committed, as always, to respecting the privacy of our clients as much as possible. However, California law requires us to report some cases of domestic violence, abuse, and assault to the police. While we can indicate that the client does not wish to be contacted, there is a small chance that she will be approached if the police feel it is necessary.

You always have the right to refuse to answer any questions you may be asked in this clinic. We will continue to give you the best medical care we can based on the information you choose to give us. If you choose to withhold information about your health, it should be with the understanding that incomplete information may affect our ability to provide the most appropriate services for you.



womens
community
clinic

Financial Responsibility Statement

Thank you for choosing the Women's Community Clinic as your health care provider. 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.

Standard Payment Policy

- Payment for services is due at the time services are rendered. We will 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.

FPACT 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.

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.

I have read and understand the above and agree to comply with the financial policies of the Women's Community Clinic, 1833 Fillmore Street, 3rd Floor, San Francisco, CA 94115.

Client Name: _____

Client Signature and Date: _____