San Francisco Department of Public Health SF Health Network **CONSENT FOR TREATMENT TERMS AND CONDITIONS**	Name: DOB: MRN: Label

I. GENERAL CONSENT

A. **Consent to Clinical, Medical Services and Surgical Treatment**: I consent to the treatment which may occur during the encounter. These may include, but are not limited to, clinical encounters, behavioral health services, Health at Home/Home Health Services, 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 provider or surgeon. I understand that the practice of clinical and behavioral health 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 admissions 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. (there may be exceptions for Behavioral Health Services)

C. **Teaching, Research and Healthcare Institution:** San Francisco Department of Public Health Programs, Clinics, Zuckerberg San Francisco General Hospital, Laguna Honda Hospital and affiliated programs 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 providers/physicians in my care. 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 for Reporting**: I understand that my medical information, photographs, and/or video in any form may be used for other SF Department of Public Health (SFDPH)/SF Health Network (SFHN) 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 SFDPH/SFHN may collect during the course of my treatment and care may be used and shared with researchers and any such use will be consistent with state and federal law, including all laws and regulations governing patient confidentiality, as written 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.

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 diagnoses, 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. Suspected child

abuse, elder abuse and those who may be a harm to themselves, or others are required by law to be reported to protective services. SFDPH also reports immunizations and TB tests to the California Immunization Registry as required by law. If you do not want this immunization information shared with other providers, you can contact the CAIR registry cairweb.org or help desk 1-800-578-1889

E. **Medication History**: I consent that SFDPH/SFHN may electronically access my medication history from external pharmacies and record this information in my medical record unless I provide SFDPH with timely written notice of my objection. I understand that the SFDPH/SFHN 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 SFDPH/SFHN health care workers are required to follow strict Body Substance Precautions in all patient/client/resident care activities to protect both patients/clients/residents 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 providers and others involved in my care that they may not be able to respond to me using the same method I used, due to protected confidential information. I understand that texting and email by either sender may not be secure communication methods as unencrypted messages could be intercepted.

H. **Health Information Exchange**: I understand my information will be available in a secure network such as Epic CareEverywhere, unless I **OPT-OUT**. This exchange allows authorized health care providers/organizations and professionals involved in my treatment, coordination of care, quality improvement, and activities related to management or payment, access to my health care records to provide me with the most informed and quality healthcare.

I. **Care Coordination**: I consent to the disclosure and use of my health information by providers within SFDPH/SFHN and between SFDPH/SFHN, its affiliates and contract providers for the purposes of care coordination. The health information shared may include but is not limited to: medical, surgical, allergies, dental, vision, hearing, nutrition, tobacco cessation, lab work, development, and mental health that may be necessary for my treatment.

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. **SFDPH/SFHN Policies:** I agree to abide by all SFDPH/SFHN policies regarding my conduct on

SFDPH/SFHN premises or in the presence of DPH Staff.

B. **Smoke Free Environment:** I acknowledge that SFDPH/SFHN is a smoke free environment and agree not to smoke inside any of its buildings or on SFDPH/SFHN premises or in the presence of DPH Staff.

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 SFDPH/SFHN premises or in the presence of DPH Staff. I agree that my personal belongings may be searched by properly authorized personnel of SFDPH/SFHN, the San Francisco Police Department or the San Francisco Sheriff's Department.

III. FINANCIAL TERMS

A. **Agreement to Reimburse SFDPH/SFHN:** I agree to pay the full costs of health care services 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 Ill, Chapter V. Article 3 (Health Code). I agree to permit SFDPH/SFHN 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 SFDPH/SFHN's right to assert a lien against my property or any action in the courts of the State of California to collect the costs of services such as hospital care, outpatient services and professional services. I understand that I will receive messages and calls on behalf of SFDPH/SFHN, 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 SFDPH/SFHN to execute all refunds resulting from any charges incurred by me or persons for whom I am the responsible party.

B. **Relationship Between SFDPH/SFHN and UCSF Providers**: I understand that the providers, physicians and surgeons, in both the inpatient, outpatient setting (inclusive of behavioral health) and radiologists, pathologists, emergency providers, anesthesiologists, and others, are not employees or agents of the hospital or SFDPH/SFHN. These providers may bill separately for professional services under the business name the San Francisco Medical Group.
Medical doctors (MD, DO) are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@rnbc.ca.gov

C. **Agreement to Reimburse San Francisco Medical Group**: I agree that in consideration of the services provided by any providers, physician, surgeon or dentist 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 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.

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

D. **Release of Information for Reimbursement**: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, SFDPH/SFHN may disclose portions of my medical record to any person or corporation which is, or may be, liable for all or any portion of SFDPH/SFHN'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 SFDPH/SFHN with timely written notice.

E. **Assignment of Benefits**: I assign and authorize direct payment to SFDPH/SFHN and the San Francisco Medical Group for all insurance benefits payable for outpatient, clinic, behavioral health or hospitalization. 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 SFDPH/SFHN and the San Francisco Medical Group and agree to pay any remaining charges for which I am legally responsible.

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

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 outpatient services or hospitalization 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**: SFDPH/SFHN 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. SFDPH/SFHN 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 SFDPH/SFHN if I belong to a plan that does not appear on the above-mentioned list. Providers, physicians and surgeons may bill separately for their services. It is my responsibility to determine if provider/physicians providing services to me contract with my health plan, if any.

J. **Health Coverage, Charity Care and Discount Payment Program Assistance**: The SFDPH/SFHN provides health coverage application assistance to uninsured and underinsured clients/ residents/patients

to help cover the cost of services. Clients, Residents, Patients may be eligible for programs that include: (1) Medi-Cal, which provides free or low-cost health insurance to eligible California residents with limited income, (2) Presumptive Eligibility Medi-Cal, which provides immediate access to temporary, no-cost Medi-Cal services while individuals apply for permanent Medi-Cal, (3) Healthy San Francisco, an affordable health care access program for San Francisco residents, (4) San Francisco County Sliding Scale Program, the county medical assistance program for San Francisco residents, and (5) Covered CA, which is the state's health insurance marketplace where California residents can shop for health plans and access financial help. Application assistance for these programs is available by contacting the Patient Access Enrollment Office at (628) 206-7800. The San Francisco Health Network (SFHN) also offers Charity Care and Discount Payment programs to clients, residents, patients who cannot afford the cost of services and who have cooperated with providing or pursuing all third-party coverage. The Charity Care and Discount Payment policy is located on the Laguna Honda Hospital website at https://lagunahondahospital.org/ for full for full eligibility requirements. Application assistance is available by contacting the Patient Financial Service Office at (415) 682-5683 or through the MyChart patient portal. The Health Consumer Alliance (https://healthconsumer.org/) provides health coverage assistance. Bay Area Legal Aid (https://baylegal.org/) provides health consumer and legal assistance. There are other organizations that will help clients, residents, patients understand the billing and payment process. The chargemaster of shoppable services (which is a listing of items that could be billed to a client, resident, patient) is located on the State of California Department of Health Care Access Information (HCAI) website at https://hcai.cagov/.

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/provider 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.

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CERTIFICATION

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

Date:	Time:
Client/Patient/Resident Signature:	
Client/Patient/Resident Printed Name:	
Client, Patient or legal Representative Signature:	
Client, Patient or legal Representative Printed Name:	
[]Refused to Sign	[ ] Physically Unable to Sign

If signed by someone other than the client/resident/patient, indicate		
Relationship:	Date of Birth:	
Witness Signature:	Printed Name:	Date/Time:
Witness Signature:	Printed Name:	Date/Time:
Interpreter Language:	Interpreter ID #	Signature if present:

Advance Directives: SFDPH/SFHN honors client/resident/patients' wishes regarding treatment decisions whenever possible. SFDPH/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. SFDPH/SFHN does not discriminate against an individual based on whether 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 SFDPH/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 SFDPH/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 WILL BE GIVEN TO THE CLIENT, PATIENT, RESIDENT OR ANYONE SIGNING THIS DOCUMENT.