PATIENT REGISTRATION FORM
(Please Print)

South of Market Health Center
Site [ ] 7th St [ ] LoPrest [ ] Clementina
[ ] Bayview [ ] Other _____
[ ] Medical/Dental [ ] Dental Only

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐
Social Security No:	Language(s) Preference:	Birth date:	Age:	E-Mail Address:
Street address/P.O. Box:	City:	State:	ZIP Code:	
Home Phone: ( )	Cell Phone: ( )			

Gender: ☐ Male ☐ Female ☐ Transgender (M/F) ☐ Transgender (F/M) ☐ Other/Unknown ☐ Choose not to disclose

Sexual Orientation: ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose not to disclose

Race:
☐ White
☐ Black/African American
☐ Asian
☐ Native Hawaiian
☐ American Indian or Alaska Native
☐ Other Pacific Islander
☐ More than One Race
☐ Choose not to disclose

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Are you a veteran?
☐ Yes
☐ No

Do you live in Public Housing?
☐ Yes
☐ No

Are you Homeless?
☐ No
☐ Yes, *please √ applicable box* →
☐ Shelter
☐ Street
☐ Doubling-Up
☐ Transitional
☐ **Other**
☐ Unknown

Do you have a Living Will/ Advance Directive?
☐ Yes
☐ No

Do you have a copy?
☐ Yes
☐ No

Are you Pregnant or here for a pregnancy test?
☐ Yes ☐ No

Family Size _____	Monthly Income $ _____	Discount% _____	Source of Income: ☐ Unemployed ☐ SSI/Disability ☐ Denied Disability Income ☐ General Assistance (GA) ☐ SNAP (Food Stamps)

You must provide proof of income within 30 days

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION *(Please give insurance card(s) to the clerk)*

Person responsible for bill:	Address (If different):	Birth Date:	Home phone#: ( )
Is this person a patient here? ☐ Yes ☐ No	Is the patient covered by insurance? ☐ Yes ☐ No		

Occupation:	Employer Phone #:	Employer Name:	Employer address:

Please indicate primary insurance ☐ Medi-Cal ☐ Medicare ☐ Third Party ☐ Self-Pay ☐ Other

Subscriber's name:	Subscriber's SS#:	Birth date:	Group #:	Policy #:	Co-payment: $

How is this person related to patient? ☐ Self ☐ Spouse ☐ Parent ☐ Other Please List:

Name of secondary insurance (if applicable):

Subscriber's name:	Subscriber's SS#:	Birth date:	Group #:	Policy #:	Co-payment: $

How is this person related to patient? ☐ Self ☐ Spouse ☐ Parent ☐ Other Please List:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The Preceding Information is True to the Best of my Knowledge:

I voluntarily request a physician, and/or nurse practitioner (mid-level provider) and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at South of Market Health Center. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). **I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents**.

X _____
Signature of Patient or Parent/Guardian
Relationship to Patient: _____

_____
Date

Summary SFMCOIP, Inc dba South of Market Health Center Notice of HIPAA Privacy Practices

This Notice describes how South of Market Health Center (SMHC) may use and share medical information about you, and how you can get access to this information. Please review this Notice carefully.

Pledge: Employees of South of Market Health Center, its affiliates and contract providers understand that information about you and your health is personal. They are committed to protecting your health information.

Who will follow the rules in this notice?

- South of Market Health Center employees, its affiliates and contract providers, must follow these rules.

You have the right to: (please see possible restrictions page 2 in the attached full Notice)

- 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 SMHC to send copies of your health record to whomever you wish (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 SMHC employees may contact you.
- Receive a paper copy of the attached SMHC Notice of Privacy Practices.

South of Market Health Center may use and disclose your health information for the purposes of treatment, payment and health care operations.

- To improve the quality of care you receive, health information may be shared by providers, both within SMHC for our own treatment purposes, and to inform the treatment that you receive from another health care provider. This sharing may include health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
- Health information may be shared to obtain payment for services that are provided to you, to assist you to pay for your care, or to obtain prior approval for treatment.
- Health information may be shared for health center operations, such as to run our facilities, make sure that all health center patients receive quality care, improve health care delivery and for learning purposes.
- 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 when you receive services for mental health, substance abuse, or STD, or for some research purposes.
- See the attached "Notice of Privacy Practices" for more information. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or call the Privacy Officer directly at (415) 503-6050.

If you believe your privacy rights have NOT been maintained while receiving South of Market Health Center services, you may file a complaint with SMHC or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with SMHC, send the complaint to the Privacy Officer at 229 7th Street, San Francisco, CA 94103, or call (415) 503-6000. To file a complaint with the Secretary, the address is U.S. Department of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 90 7th Street, Suite 4-100, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

Acknowledge receipt of the South of Market Health Center "Notice of Privacy Practices". I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the Notice attached.

Signature: _____ **Date**: _____

Printed Name: _____ Relation (if other than patient): _____

Patient/client declined to sign receipt (staff signature): _____

Patient/client unable to sign (witness signature): _____

Reason unable: _____ Interpreter: _____