SAN FRANCISCO COMMUNITY HEALTH CENTER

Welcome to the Wellness Clinic at San Francisco Community Health Center. We are honored that you have chosen us as your medical home.

We are a fully-licensed, federally qualified health center serving diverse local communities, including people of color and the LGBTQ community. Our team provides respectful, compassionate health care that focuses on you as a whole person. We provide primary care, STI/HIV testing, birth control, family planning, psychotherapy, case management, and specialized services for the Trans community. Your medical and support staff can also connect you the services that you need to reach health, wellness, and equality.

Our Tenderloin clinic location is open:
**Monday-Friday:** 8:45 AM – 4:45 PM, closed daily from 12:00 PM – 1:00 PM

Our Castro clinic location is open for Dental and Behavioral Services
**Monday - Friday:** 9:00 AM – 5:00 PM, closed from 12:00 PM – 1:00 PM

Please give us a call at **415-292-3400** or email to **TheClinic@SFCommunityHealth.org** to schedule future appointments. For prescriptions refill leave a voicemail at **415-292-3420 ext. 708**. If you have an urgent medical or mental health question after hours, please dial **415-292-3400**.

Please complete registration forms enclosed in this new patient packet and return to the front desk, with your photo ID and insurance card (if applicable) to obtain your first appointment. Please bring your photo ID and insurance card with you to each appointment.

We are currently accepting insurances such as, Medi-Cal, Medicare, Anthem Blue Cross/ Blue Shield, San Francisco Health Plan, etc; with an exception of Kaiser, VA, and United Health Care. We charge the Insurance companies, but they might charge you depending your coverage/copays. Ask the receptionist for more details. You are encouraged to contact your insurance provider to ask if they will cover services at our clinic or for any copays. We also offer a sliding fee scale program for individuals who are unable to obtain insurance. We will assist you with eligibility screening and healthcare enrollment to the applicable medi-cal, ADAP, PrEP AP, or Covered CA.

Please arrive at least 20 minutes prior to your first appointment's scheduled time. This helps our support staff assist you with any additional introductory paperwork, registration, and concerns. If you need to cancel you appointment, please try to provide at least 24 hours notices, as another individual may find need for your slot. We also offer Same Day appointments for urgent medical needs after being triaged by nursing staff. This helps our clinic provide as much service to those who wish to seek healthcare at our facility as possible.

We are very excited to continue to service you in the near future. Welcome to our clinic!

Warmly,
San Francisco Community Health Center

## TAKE AN ACTIVE ROLE IN YOUR OWN HEALTHCARE

1. Be prepared for healthcare visits
2. Ask questions
3. Be open and honest with the healthcare team
4. Take part in making decisions
5. Follow your care plan

## FREQUENT QUESTIONS

### How do I request a refill?

When you need a refill for a medication prescribed by our clinic, please call your pharmacy and request a refill. It is helpful to have the prescription number on the bottle or the packaging available when you call. The pharmacy will contact our office if approval is needed. If you do not have refills remaining, please still contact the pharmacy and they will send a refill request directly to us, or leave a voicemail at our refill line 415-292-3420 ext. 708

Please call the pharmacy at least 72 hours (3 business days) before you run out of medication for refills to be processed. For pain medication or benzos at least 5 business days.

If you are planning to go on vacation, please check your supply. If you need an early refill please notify your pharmacy.

### Why did I receive a bill from Quest Laboratories?

We use Quest Diagnostics to process most lab testing conducted at SFCHC. Quest Diagnostics bills your insurance separately for lab processing. If your insurance rejects the claim for any reason, you may receive a bill from Quest Diagnostics directly. Please contact Quest directly, online (questdiagnostics.com) or by phone (1-800-877-6241 Mon-Th 8:30am-5pm and Fri 9am-pm) to address.

### Do I have to have Advanced Health Care Directive?

An Advance Health Care Directive is a legal document that allows individuals to state in advance their healthcare wishes if they become unable to make their own decisions. In California, an Advance Directive consists of two parts: (1) Selection of an agent for healthcare; and (2) an individual's health care instructions.

How long is an Advance Health Care Directive in effect? In California, an Advance Health Care Directive stays in effect until you change it. You can change your mind at any time, as long as you have the "capacity" to make decisions. It is a good idea to review your Advance Health Care Directive yearly to make sure your wishes are up to date and stated.

Who can fill out an Advance Health Care Directive? Any person 18 years or older who can talk to you about your wishes, can be there for you when you need them, you trust to follow your wishes and do what is best for you, you trust to know your medical information, and has the "capacity" to make health care decisions. "Capacity" means the person understands the nature and consequences of the proposed healthcare, including the risks and benefits.

What will happen if I do not choose a medical decision maker? If you are not able to make your decisions, your doctors will turn to family and friends or a judge to make decision for you. This person may not know what you want.

Who should have a copy of the Advance Health Care Directive? You (keep your Advance Health Care Directive in a safe place, but easily accessible.), your agent (the person designated to make health care decisions if you are unable to do so.), and each of your health care providers. It is important that you keep track of who has a copy of your Advance Health Care Directive in case you make changes in the document.

## Patient Demographic Form

**Preferred Name**_____ **Last Name**_____ **Gender Pronouns** _____
(Preferred) (Preferred) (He, She, or They)

**Legal First Name**_____ **Last Name**_____ **Middle Name Initial**_____
(Legal name on ID/insurance, if different) (Legal)

**Date of Birth**_____/_____/_____ **SSN** _____–_____–_____

**Address**_____ **City**_____ **State**_____ **Zip**_____

**Living Situation:** □ permanently housed □ automobile □ group home □ street □ shelter □ transitional housing □ SRO □ other: _____

**Mailing Address** _____ **City**_____ **State**_____ **Zip**_____
(if different than above)

**Primary Phone** _____ **Secondary Phone** _____ **Email** _____

**Country of Birth**_____ **Year Arrived in the U.S.** _____

**__Emergency Contact__**

**Full Name**_____ **Contact Phone Number** _____ **Relationship** _____

**Please check all that apply**

| Gender Identity | Gender at Birth | Sexual Orientation |
|---|---|---|
| □ Male ☐Two Spirit<br>□ Female ☐Questioning<br>□ Trans-MTF<br>□ Trans-FTM<br>□ Intersex<br>□ Choose not to disclose<br>□ Non-Binary/ Gender Queer<br>□ Other-_____ | □ Male<br>□ Female<br>□ Intersex<br>□ Decline to state<br>□ Other-_____ | □ Gay ☐Lesbian<br>□Queer<br>□ Heterosexual/Straight<br>□ Bisexual<br>□ Asexual ☐Pansexual<br>□ Unknown<br>□ Choose not to disclose<br>□ Other-_____ |

| Marital Status | Number of dependents in household (including self) | Employment Status | Source of Income | Monthly Income |
|---|---|---|---|---|
| ☐Single/Not married<br>☐Divorced/Separated<br>☐Domestic Partner<br>☐Married<br>☐Widowed<br>☐Legally Separated<br>☐Unkown<br>☐Other-_____ | _____ | ☐Employed ☐FT ☐PT<br>☐Unemployed □Due to disability<br>☐Student ☐FT ☐PT<br>☐Unknown<br>☐Military ☐Active ☐Retired<br>☐Seasonal<br>☐Retired<br>☐Self-employed<br>☐Other-_____ | ☐Alimony/Child Support<br>☐Food stamps<br>☐General/Public Assistance<br>☐Housing/Rental Subsidy<br>☐Social Security<br>☐Retirement Pension<br>☐Social Security<br>☐Other-_____ | _____ |

| Medical Insurance Status | Disabled | Migrant |
|---|---|---|
| □ Uninsured<br>□ Medi-Cal/Medicaid<br>□ Medicare<br>□ Healthy SF<br>□ Aetna<br>□ Other: _____<br>*Insurance ID No:* _____ | (Having a physical or mental condition that limits movements, senses, or activities.)<br>☐Yes<br>☐No | (A person who moves from one place to another within a country.)<br>☐Yes<br>☐No |

| Ethnicity | Race | Primary Language |
|---|---|---|
| ☐Another Hispanic, Latino(a)/Spanish Origin<br>☐Cuban<br>☐Mexican, Mexican American, or Chicano/a<br>☐Not Latino(a)/ Hispanic<br>☐Decline to state<br>☐Puerto Rican<br>☐Unknown | ☐American Indian<br>☐Alaska Native<br>☐Black/African American<br>☐Chinese<br>☐Filipino<br>☐Japanese<br>☐Korean<br>☐Native Hawaiian/Pacific Islander<br>☐Other Asian<br>☐Decline to state<br>☐Unknown<br>☐White/Caucasian<br>☐Other: _____ | □ English<br>□ Cantonese<br>□ Mandarin<br>□ Spanish<br>□ Tagalog<br>□ Vietnamese<br>□ Other-_____ |

| How did you hear about | Preferred Method of Contact | Consent to Leave Detailed Messages |
|---|---|---|
| ☐Advertisements<br>☐Brochures or flyers<br>☐Health plan or insurer<br>☐Search engine (e.g. Google, Yahoo, etc.)<br>☐Referral from outside<br>☐Referral from SF Community Health Center<br>☐Website (www.sfcommunityhealth.org)<br>☐Word by mouth (family, friends, other clients)<br>☐Other-_____ | ☐Phone (Calls)<br>☐Mobile (Text Message)<br>☐Email<br>☐Other: _____ | ☐Yes<br>☐No |

Which services are you interested in? ☐ Primary Care ☐Behavioral Health ☐Dental

What would you like to talk about with your healthcare provider in your first visit?

_____

_____

SAN FRANCISCO COMMUNITY HEALTH CENTER

# PATIENT NOTIFICATION ON SLIDING FEE DISCOUNT PROGRAM

We are a federally qualified health center offering on-site primary medical care, mental health care, and social/ community support services. Services are provided on a sliding scale based on income level and family size and no other criteria. We accept private insurance through Aetna, Anthem Blue Cross, and Humana in addition to Medi-Cal and Medicare. You may still be eligible for our sliding fee discount program if even if you have third party coverage.
We will not turn you away if you are unable to pay for high quality health care.
SFCHC provides access to health care services regardless of a person's inability to pay to ALL patients and serves everyone.

**Eligibility is based on income and family size and no other criteria**. To determine your sliding fee discount level, you must provide proof of income and provide family size and complete an SFDP application. You must re-enroll in the program each year or if your income or family size changes whichever comes first. To determine your sliding fee discount level, you must provide proof of income and provide family size.

**Income is defined** as: Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.

- Noncash benefits (such as food stamps and housing subsidies) **do not** count.
- Before taxes.
- Excludes capital gains or losses.
- If a person lives with a family, add up the income of all family members. (Non-relatives, such as housemates, do not count.)

All income documents that exist for any member of the applicant's household (included as family) must be provided. The following constitute acceptable proof of income:

- Two most current pay stubs
- Last year's income tax return
- Social Security check stub
- Retirement Income
- Unemployment Income, Public Assistance
- Alimony, Child Support
- Letter from current employer stating annual income

**Family members** who are considered for the eligibility criteria for Sliding fee program include the following individuals who live in the same household:

- Patient
- Spouse (including domestic partner)
- The natural, adopted, or step-child(ren) of the patient
- The parents of the patient if he/she is under 18, unmarried and living with their parents.

Note: A parent or legal guardian must accompany adolescents under 18 years of age, unless confidential services are requested.

Visit Fee's/Labs/Imaging Range from: $10 - $35 (or Full Cost for patients with income above 200% of FPL) your fee will be determined by a review of your application and verification of eligibility based on income and family size.

To make a registration appointment or for additional information: Please call the San Francisco Community Health Center at 415-292-3400 Visit us on line at www.sfcommunityhealth.org

**Stop by our office locations**:

**Tenderloin Location:**
726 Polk Street 4th Floor
San Francisco, CA 94109

**Castro location**:
1800 Market Street
Suite 401
San Francisco, CA 94102

**Services Offered** e.g.: Primary Care, Transgender health, LGBTQIA Health, Mental health, Substance Use Treatment, Health Education.

SAN FRANCISCO COMMUNITY HEALTH CENTER

# Sliding Fee Discount Program Interest Form (new patients)

*The Sliding Fee Discount Program offers financial discounts for medical services to qualifying participants who fall under 200% of the Federal Poverty Level.*

☐ I do wish to participate in the Sliding Fee Discount Program provided by San Francisco Community Health Center (SFCHC) and receive more information regarding this, to see if I qualify. I am willing to provide proof of income and family size.

☐ I do not wish to participate in the Sliding Fee Program provided by SFCHC.

Patient Name:_____

Signature _____

Date: _____ DOB:_____

**Official use only:** Patient MR#_____

Verified by Staff(name): _____ Staff Signature:_____

Patient Income: _____ (M=monthly/ A=annual) Patient Family size:_____

Preliminary eligibility class (circle): **A** **B** **C** **D** **E** (100% of charges)

If patient was interested, sliding fee program was discussed and application provided to the patient:

**Yes** ☐ **No** ☐ if no explain: _____

SAN FRANCISCO COMMUNITY HEALTH CENTER

| | |
|---|---|
| **Name:** | |
| **Address:** | |
| **City, State:** | |
| **Zip Code:** | |
| **Telephone:** | |
| **Date of Birth:** | |
| **Chart Number:** | |
| **Household Includes:** | Yourself<br>Spouse (domestic partner)<br>Natural, adopted or step-child of the patient<br>Your parents if you are under 18, unmarried and living with them |

**San Francisco Community Health Center**

***Sliding Fee Eligibility Form***

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence
You must verify your income once a year or when it changes.
Your annual income will be used to calculate the level of your payment. Acceptable forms of proof of income are:

| | |
|---|---|
| Two most current pay stubs<br>Social Security check stub<br>Unemployment Income, Public Assistance<br>Letter from current employer stating annual income | Last year's income tax return<br>Retirement Income<br>Alimony, Child Support |

Today's Date: _____

Number of people living in your home? _____

What is your marital status? ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Other

Amount of Household Income?

**Monthly or**

**Annual**

| You | Your Spouse | Your Children | Other Person | Total Family Income |
|---|---|---|---|---|
| $ | $ | $ | $ | $ |
| $ | $ | $ | $ | $ |

Do you receive any income from any of the following sources, and if so, how much?

| Sources | You | Your Spouse | Your Children | Other Person | Total Sources Monthly | Total Sources Annually |
|---|---|---|---|---|---|---|
| Unemployment Compensation | | | | | $ | $ |
| Workers Compensation | | | | | $ | $ |
| Social Security | | | | | $ | $ |
| Supplemental Security income | | | | | $ | $ |
| Public Assistance | | | | | $ | $ |
| Veterans Payments | | | | | $ | $ |
| Survivors benefits | | | | | $ | $ |
| Retirement Pension | | | | | $ | $ |
| Interest/Dividends Income | | | | | $ | $ |
| Rental / Royalties Income | | | | | $ | $ |
| Income from Estates/Trusts | | | | | $ | $ |
| Educational assistance | | | | | $ | $ |
| Child Support, Alimony | | | | | $ | $ |
| Assistance from outside the household | | | | | $ | $ |
| Other Misc.(Specify) | | | | | $ | $ |

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, list below ☐ No ☐

| Name of Family member: | Date of Birth: |
|---|---|
| 1 Self | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |

I declare the above information is true and have given SFCHC. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

| | | |
|---|---|---|
| Signature: | Date: | ***Clinic Purpose Only***<br>Income Code: |
| Name | Chart#: | ***Documents stored in EcW*** ☐ |

## *Sliding Fee Eligibility-Self Declaration Form*

***if applicable***

SELF-ATTESTATION OF INCOME

Self-attest of income may only be used in special circumstances. Patients who are unable to provide written verification must indicate below why (s)he, they is unable to provide independent verification.

_____

_____

STATEMENT

I _____ attest that I am unable to provide written verification of my income.

| | | |
|---|---|---|
| Patients Signature: | Date: | |
| Signature of authorized Staff: | Date: | |

**For Official Use only:**

**Income verified:** _____ **if not, self-attestation completed** _____

**Total annual income recalculation verified in the amount of: $** _____ **Family size :** _____

**Sliding Fee class eligibility: A B C D E (100% of charges)**

**Show Math Calculation for Patient Placement on Sliding Fee Scale:**

**Staff Signature:** _____

SAN FRANCISCO COMMUNITY HEALTH CENTER

# Social History Intake Form

Please fill out the following fields to the best of your ability.
This information helps us prepare for your first visit and understand your needs.
A nurse will be reaching out to you before your first appointment to discuss this with you in more detail

**Name**: _____ **Date of Birth**: _____

**Are you currently receiving services at another clinic?** ☐ Yes ☐ No

Clinic: _____ Provider Name: _____

**Do you have a case manager?** ☐ Yes ☐ No

Case Manager Name: _____

**Have you experienced a recent hospitalization or Emergency Room visit?** ☐ Yes ☐ No

Hospital:_____

**Information and Demographics**

| Question | Response | Notes | Provider Use: |
|---|---|---|---|
| 1. Marital Status | ☐ Never married<br>☐ Married<br>☐ Divorced<br>☐ Separated<br>☐ Widowed | | |
| 2. Housing | ☐ Unhoused<br>☐ Shelter<br>☐ Renting<br>☐ Owning<br>☐ Living with relatives | | |
| 2a. Number of adults in house | | | |
| 2b. Number of children in house: | | | |
| 2c. Living with | ☐ Alone<br>☐ Spouse<br>☐ Significant other<br>☐ Friends<br>☐ Parents<br>☐ Siblings<br>☐ Foster children | | |
| 2d. Pets | ☐ None<br>☐ Cats<br>☐ Dogs<br>☐ Bird<br>☐ Reptiles<br>☐ Exotic animals | | |
| 2e. Home Smoke Detector Use | ☐ None<br>☐ Smoke detector<br>☐ Carbon monoxide detector | | |
| 3. Religion | | | |
| 4. Level of Education | ☐ Some high school<br>☐ High school<br>☐ Some college<br>☐ Finished college<br>☐ Professional schools/Masters/PhD | | |

| Question | Response | Notes | Provider Use: |
|---|---|---|---|
| 5. Occupation | ☐ Works at home<br>☐ Works part-time<br>☐ Works full-time<br>☐ Office worker<br>☐ Professional<br>☐ Manual work<br>☐ Unemployed | Specify: | |
| 5a. Occupational Exposure | ☐ None<br>☐ Toxic chemicals<br>☐ Noise exposure<br>☐ Infectious agents<br>☐ Repetitive physical stress<br>☐ Do not know | | |
| 6. Exercise | ☐ None<br>☐ Less than 1 time per week<br>☐ 1-2 times per week<br>☐ 2-3 times per week<br>☐ 3-4 times per week | | |
| 7. Community Involvements | ☐ None<br>☐ Belongs to a religious group<br>☐ Active in community organizations<br>☐ Active in sports or recreational activities | | |
| 8. Travels outside of United States in the last 6 months | ☐ None<br>☐ Travels to South America<br>☐ Travels to Europe<br>☐ Travels to Asia<br>☐ Travels to Africa | | |

**Patient History**

| Question | Response | Notes | Provider Use |
|---|---|---|---|
| Interpersonal/Domestic Violence | ☐ None<br>☐ History in the past<br>☐ Has restraining order<br>☐ Feels unsafe at home<br>☐ Has safety plan | | |
| Physical Abuse | ☐ None<br>☐ Current<br>☐ Has experienced in the past, none currently | | |
| Sexual Abuse | ☐ None<br>☐ History in the past<br>☐ Ongoing in relationship<br>☐ Has safety plan | | |
| Suicidal Thoughts | ☐ None<br>☐ Current<br>☐ Has had in the past, none currently | | |
| Verbal Abuse | ☐ None<br>☐ Occasional<br>☐ Frequent<br>☐ Seeking counseling<br>☐ Has safety plan | | |

**Sexual History**

| Question | Response | Notes | Provider Use |
|---|---|---|---|
| 1. Engaged in sexual activity in the last 12 months? | ☐ Yes<br>☐ No **(skip to #2)** | | |
| 1a. Number of partners in the past 12 months: | | | |
| 1b. Sexual partners' gender | ☐ Cisgender female<br>☐ Cisgender male<br>☐ Trans female<br>☐ Trans male<br>☐ Gender non-conforming<br>☐ Non-binary | | |
| 1c. Type of sexual activity | ☐ Insertive anal<br>☐ Insertive vaginal<br>☐ Insertive oral<br>☐ Receptive anal<br>☐ Receptive vaginal<br>☐ Receptive oral | | |
| 1d. Protection methods again STIs | ☐ None<br>☐ Condoms<br>☐ PrEP<br>☐ Mutual monogamous relationship with recently tested partner<br>☐ Other: _____ | | |
| 1e. Date of last condomless anal or vaginal intercourse (mm/dd/yyyy) | | | |
| 1f. Any sexual or injecting partners living with HIV? | ☐ Yes<br>☐ No | | |
| 1g. Exchanged sex for money? | ☐ Yes<br>☐ No | | |
| 1h. Previous STI Diagnosis? | ☐ Yes<br>☐ Gonorrhea<br>☐ Chlamydia<br>☐ Syphilis<br>☐ HIV<br>☐ Herpes<br>☐ None | | |
| 2. Familiar with PrEP? | ☐ Yes<br>☐ No | | |

**Tobacco Use**

| Question | Response | Notes | Provider Use |
|---|---|---|---|
| 1. Tobacco use status | ☐ Current user<br>☐ Former user<br>☐ Non-user **(skip to next section)**<br>☐ Light tobacco user<br>☐ Heavy tobacco user | | |
| 1a. How often do you smoke cigarettes? | ☐ Every day<br>☐ Some days, but not every day | | |
| 1b. How soon after you wake up do you smoke your first cigarette? | ☐ Within 5 minutes<br>☐ 6-30 minutes<br>☐ 31-60 minutes<br>☐ After 60 minutes | | |
| 1c. Are you interested in quitting? | ☐ Ready to quit<br>☐ Thinking about quitting<br>☐ Not ready to quit | | |
| 1d. When did you start smoking? (mm/dd/yyyy) | | | |
| Patient counselled on the dangers of tobacco use and urged to quit? Y / N | | | |

**Alcohol**

| Question | Response | Notes | Provider Use |
|---|---|---|---|
| 1. Did you have a drink containing alcohol in the past year?<br>A drink is 1 serving of:<br>12 oz beer, 8 oz malt liquor,<br>5 oz wine, 1.5oz distilled spirits. | ☐ Yes<br>☐ No **(skip to next section)** | | |
| 1a. How often did you have 6 or more drinks on one occasion in the past year? | ☐ Never<br>☐ Less than monthly<br>☐ Monthly<br>☐ Weekly<br>☐ Daily or almost daily | | |
| 1b. how many drinks did you have on a typical day when you were drinking in the past year? | ☐ 1-2 drinks<br>☐ 3-4 drinks<br>☐ 5-6 drinks<br>☐ 7-9 drinks<br>☐ 10 or more drinks | | |
| 1c. How often did you have a drink containing alcohol in the past year? | ☐ Never<br>☐ Monthly or less<br>☐ 2-4 times per month<br>☐ 2-3 times per week<br>☐ 4 or more times per week | | |

**Drug Use**

| Question | Response | Notes | Provider Use |
|---|---|---|---|
| 1. Have you used drugs other than those for medical reasons in the past 12 months? | ☐ Yes<br>☐ Heroin<br>☐ Cocaine<br>☐ PCP<br>☐ Ketamine<br>☐ Marijuana<br>☐ Prescription opiates<br>☐ Ecstasy<br>☐ LSD<br>☐ Crack<br>☐ Methamphetamine<br>☐ No **(skip to next section)** | | |
| 1a. If applicable, heroin use route? | ☐ Injected<br>☐ Snorted<br>☐ Smoked | | |
| 1b. If applicable, cocaine use route? | ☐ Injected<br>☐ Snorted<br>☐ Smoked | | |
| 2. Are you in a treatment program? | ☐ Yes<br>☐ No **(skip to #3)** | | |
| 2a. Name of program | | | |
| 2b. Type of program | ☐ Detox<br>☐ Methadone<br>☐ Residential treatment<br>☐ Outpatient<br>☐ 12 step<br>☐ Other: _____ | | |
| 3. Have you ever injected drugs? | ☐ Yes<br>☐ Yes, currently injecting<br>☐ No **(skip to #4)** | | |
| 3a. Date of last injection (mm/dd/yyyy) | | | |
| | | Discussed safe injection/needle exchange? Y / N | |
| 4. Do you currently use drugs? | ☐ Yes<br>☐ No | | |
| 4a. How many months ago did you last use drugs? | ☐ Less than 6 months ago<br>☐ 6-12 months ago<br>☐ 12-24 months ago<br>☐ More than 24 months ago | | |
| 4b. Do you need clean needles? | ☐ Yes<br>☐ No | | |
| 4c. Do you want a schedule for needle exchange? | ☐ Yes<br>☐ No | | |
| 4d. Are you interested in treatment | ☐ Yes<br>☐ No | | |
| | | Relapse prevention discussed? Y / N | |

**Tests**

If you have had any of the following tests done, please list the approximate date and what the results were, if known.

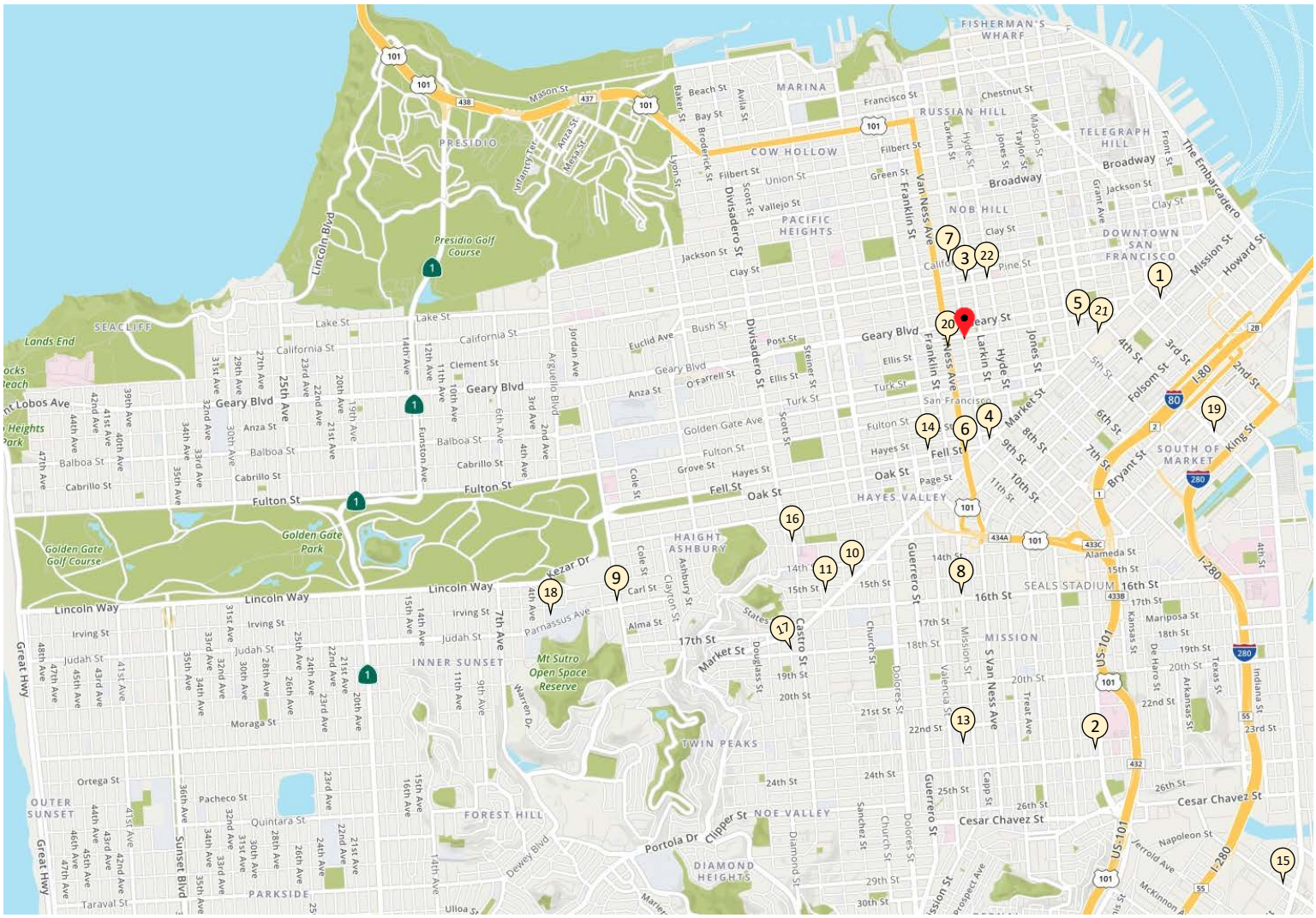
| Test | Approximate Date | Result |
|---|---|---|
| Pap smear (cervical cancer screening) | | |
| Mammogram | | |
| Colonoscopy | | |
| HIV | | |
| Hepatitis C testing | | |
| Last dental exam | | |
| Last eye exam | | |

**Medications**

Please list all medications you are currently taking.

| Medication Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Preferred Pharmacy




**Popular Pharmacies** (Circle one)

1. Walgreens: 1189 Potrero Ave
   Intersection with 24th St
2. Walgreens: 1300 Bush St Intersection with Larkin St
3. Walgreens: 1301 Market St
   Intersection with 9th St
4. Walgreens: 135 Powell St
   Between O'farrell St and Ellis St
5. Walgreens: 1524 Polk St Intersection with California St
6. Walgreens: 199 Parnassus Ave
   Intersection with Stanyan St
7. Walgreens: 2145 Market St Between Sanchez St and Church St
8. Walgreens: 2262 Market St Between Noe St and Sanchez St
9. Walgreens: 2494 San Bruno Ave
   Intersection with Gaven St
10. Walgreens: 2690 Mission St
    Intersection with 23rd St
11. Walgreens: 45 Castro St
    Intersection with Duboce Ave
12. Walgreens: 498 Castro St
    Intersection with 18th St
13. Walgreens: 500 Parnassus J Level
    Between 3rd Ave and Hillway Ave
14. Walgreens: 670 4th St
    Intersection with Townsend St
15. Walgreens: 825 Market St
    Between 4th St and 5th St
16. Walgreens: 965 Geneva Ave
    Intersection with Paris St

17. Other:

Name: _____

Address: _____

Phone: _____

Fax: _____

# Authorization for Release and/or Disclosure of Health Information

I authorize the disclosure of my protected health information (PHI) to the persons/entities as described below. I understand this authorization is voluntary. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I hereby give permission to San Francisco Community Health Center (SFCHC) to disclose my PHI in the manner described herein.

Patient's name: _____ AKA: _____ DOB: _____

**PHI MAY BE DISCLOSED:** ☐ **TO AND/ OR** ☐**FROM**

Person/Facility: _____

Address: _____

Phone: _____ Fax: _____

**PHI MAY BE DISCLOSED:** ☐ **TO AND/ OR** ☐**FROM**

Facility: San Francisco Community Health Center

Address: 730 Polk st, 4th floor, San Francisco, CA 94109

Phone: (415) 292 – 3400 Fax: (415) 292 – 3418

**FOR THE PURPOSE OF:** Continuity-Transfer of Care / For Communication / Referral: _____

**DATES OF TREATMENT AND/OR SPECIFIC MEDICAL CONDITION**: _____

Specify records to be released and/or disclosed

- ☐ Complete Medical Record(s)
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Lab Tests
- ☐ X-Ray Report
- ☐ Immunizations Records
- ☐ Other, specify: _____

Initial below for **protected classes** of information

- _____ Mental Health Treatment
- _____ Alcohol/Substance use
- _____ HIV/AIDS & STI Treatment/Results
- _____ Developmental Disabilities

Your request will be deemed to include any information related to sexually transmitted infection, alcohol or substance use or treatment, or mental health/psychology/psychiatry that may be within your above request, unless you specifically state your objection here:

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before SFCHC received and processed a written notice of revocation. I understand that if I did not specify duration and if I do not revoke it, **this authorization will expire one year from the date of signature below**. To revoke this authorization, I understand that I must send a written request to: San Francisco Community Health Center, ATTN: Privacy Officer, 726 Polk Street, 4th Floor, San Francisco, CA 94109.

**ACKNOWLEDGMENT**

Please sign and date: I have had full opportunity to read and consider the consents of this authorization, and I confirm that the contents are consistent with my direction to San Francisco Community Health Center to release nonpublic protected health information. I understand that San Francisco Community Health Center will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

By: _____ _____ _____

Participant Name (Print) Participant Signature Date

If you are not the participant please also complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof of your relationship to the participant (e.g. Power of Attorney, legal guardian).

By: _____ _____ _____

Participant Representative Name (Print) Participant Representative Signature Date

□ Parent of Minor Child □ Legal Guardian □ Power of Attorney □ Executor □ Other:_____

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☐ Parent of Minor Child ☐ Legal Guardian ☐ Power of Attorney ☐ Executor ☐ Other:_____

# Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

*Your Name* *Relationship*

**Do you have any of the following diseases or problems:** *(Check DK if you Don't Know the answer to the the question)*

| | Yes | No | DK |
|---|---|---|---|
| Active Tuberculosis | ☐ | ☐ | ☐ |
| Persistent cough greater than a 3 week duration | ☐ | ☐ | ☐ |
| Cough that produces blood | ☐ | ☐ | ☐ |
| Been exposed to anyone with tuberculosis | ☐ | ☐ | ☐ |

***If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.***

**Referred By:**

## Dental Information

*For the following questions, please mark (X) your responses to the following questions.*

| | Yes | No | DK |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment? | ☐ | ☐ | ☐ |
| Have you had any problems associated with previous dental treatment? | ☐ | ☐ | ☐ |
| Is your home water supply fluoridated? | ☐ | ☐ | ☐ |
| Do you drink bottled or filtered water? | ☐ | ☐ | ☐ |

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

| | | | |
|---|---|---|---|
| Are you currently experiencing dental pain or discomfort? | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Do you have earaches or neck pains? | ☐ | ☐ | ☐ |
| Do you have any clicking, popping or discomfort in the jaw? | ☐ | ☐ | ☐ |
| Do you brux or grind your teeth? | ☐ | ☐ | ☐ |
| Do you have sores or ulcers in your mouth? | ☐ | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ | ☐ |
| Do you participate in active recreational activities? | ☐ | ☐ | ☐ |
| Have you ever had a serious injury to your head or mouth? | ☐ | ☐ | ☐ |

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

## Medical Information

*Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK |
|---|---|---|---|
| Are you now under the care of a physician? | ☐ | ☐ | ☐ |

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

| | | | |
|---|---|---|---|
| Are you in good health? | ☐ | ☐ | ☐ |
| Has there been any change in your general health within the past year? | ☐ | ☐ | ☐ |

If yes, what condition is being treated?

Date of last physical exam:

| | Yes | No | DK |
|---|---|---|---|
| Have you had a serious illness, operation or been hospitalized in the past 5 years? | ☐ | ☐ | ☐ |

If yes, what was the illness or problem?

| | | | |
|---|---|---|---|
| Are you taking or have you recently taken any prescription or over the counter medicine(s)? | ☐ | ☐ | ☐ |

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

*(Check DK if you Don't Know the answer to the question)*

Do you wear contact lenses? Yes ☐ No ☐ DK ☐

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐ DK ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? Yes ☐ No ☐ DK ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes ☐ No ☐ DK ☐

Date Treatment began: _____

Do you use controlled substances (drugs)? Yes ☐ No ☐ DK ☐

Do you use tobacco (smoking, snuff, chew, bidis)? Yes ☐ No ☐ DK ☐
If so, how interested are you in stopping?
*Circle one:* VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Yes ☐ No ☐ DK ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

**WOMEN ONLY** Are you:

Pregnant? Yes ☐ No ☐ DK ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? Yes ☐ No ☐ DK ☐
Nursing? Yes ☐ No ☐ DK ☐

**Allergies.** Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

| | Yes | No | DK |
|---|---|---|---|
| Local anesthetics | ☐ | ☐ | ☐ |
| Aspirin | ☐ | ☐ | ☐ |
| Penicillin or other antibiotics | ☐ | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills | ☐ | ☐ | ☐ |
| Sulfa drugs | ☐ | ☐ | ☐ |
| Codeine or other narcotics | ☐ | ☐ | ☐ |
| Metals | ☐ | ☐ | ☐ |
| Latex (rubber) | ☐ | ☐ | ☐ |
| Iodine | ☐ | ☐ | ☐ |
| Hay fever/seasonal | ☐ | ☐ | ☐ |
| Animals | ☐ | ☐ | ☐ |
| Food | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |

***Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.***

| | Yes | No | DK |
|---|---|---|---|
| Artificial (prosthetic) heart valve | ☐ | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ | ☐ |
| Damaged valves in transplanted heart | ☐ | ☐ | ☐ |
| Congenital heart disease (CHD) | | | |
| Unrepaired, cyanotic CHD | ☐ | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ | ☐ |

*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

| | Yes | No | DK |
|---|---|---|---|
| Cardiovascular disease | ☐ | ☐ | ☐ |
| Angina | ☐ | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ | ☐ |
| Damaged heart valves | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Other congenital heart defects | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ | ☐ |
| Abnormal bleeding | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | ☐ |
| If yes, date: _____ | | | |
| Hemophilia | ☐ | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Autoimmune disease | ☐ | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ | ☐ |
| Systemic lupus erythematosus | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Cancer/Chemotherapy/ Radiation Treatment | ☐ | ☐ | ☐ |
| Chest pain upon exertion | ☐ | ☐ | ☐ |
| Chronic pain | ☐ | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ | ☐ |
| Eating disorder | ☐ | ☐ | ☐ |
| Malnutrition | ☐ | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ | ☐ |
| G.E. Reflux/persistent heartburn | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |

| | Yes | No | DK |
|---|---|---|---|
| Glaucoma | ☐ | ☐ | ☐ |
| Hepatitis, jaundice or liver disease | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ |
| Fainting spells or seizures | ☐ | ☐ | ☐ |
| Neurological disorders | ☐ | ☐ | ☐ |
| If yes, specify: _____ | | | |
| Sleep disorder | ☐ | ☐ | ☐ |
| Do you snore? | ☐ | ☐ | ☐ |
| Mental health disorders | ☐ | ☐ | ☐ |
| Specify: _____ | | | |
| Recurrent Infections | ☐ | ☐ | ☐ |
| Type of infection: _____ | | | |
| Kidney problems | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Persistent swollen glands in neck | ☐ | ☐ | ☐ |
| Severe headaches/ migraines | ☐ | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ | ☐ |
| Sexually transmitted disease | ☐ | ☐ | ☐ |
| Excessive urination | ☐ | ☐ | ☐ |

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐ DK ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes ☐ No ☐ DK ☐
Please explain:

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

**FOR COMPLETION BY DENTIST**

Comments:

San Francisco Community Health Center

# INFORMED CONSENT FOR THERAPY

## HOW LONG DOES THERAPY TAKE?

It is always hard to know how many sessions this will take. Your therapist will suggest a treatment plan after your initial assessment and discuss options with you. A good rule of thumb is to commit to six sessions and then on session six, reassess the goals.

## CANCELLATION POLICY

Please discuss this with your individual therapist, as each therapist has a practice of how to manage missed or canceled sessions.

## RISKS AND BENEFITS?

Therapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Therapy has also been shown to have benefits for people including (but not limited to): more satisfying relationships, solutions to specific problems, significant reductions in stress level, and an increased ability to live a meaningful life. However, there are no guarantees as to what you will experience.

## CONFIDENTIALITY

Legal and ethical responsibilities require that our therapy sessions remain confidential. Therefore, the information discussed during your therapy sessions is confidential with some exceptions. Exceptions will be made only if you endanger, or may endanger, yourself or others, and/or in the case of child abuse or elder abuse. In these cases the law requires your therapist to share certain information with specific outside parties.

Under the following specific circumstances your therapist may be compelled or allowed by law or ethical guidelines to disclose confidential information:

· You are a danger to yourself or to the person or property of others or unable to care for yourself. Involuntary hospitalization may be required under extreme circumstances.

· Your records are subpoenaed or my testimony is required and your therapist must comply with a court order.

· You make a serious threat of physical violence against a reasonably identifiable victim.

· Your therapist reasonably suspects that a minor is the victim of neglect or sexual, physical, or emotional abuse, or an elder or dependent adult is the victim of abuse.

· You seek your therapist's services in order to enable yourself or another to commit a crime, or to avoid detection of or apprehension for a previous crime.

· You may be asked to sign a Release of Information that will allow your therapist to consult with a third party (for example, a physician, psychiatrist, former therapist, or family member) in the interest of furthering your therapist's work with you. This is completely voluntary.

· In order to ensure quality service your therapist may periodically discuss your therapy in consultation with other professionals within San Francisco Community Health Center who are a part of your care team. This is for the purpose of improving your care and receiving feedback from consultants and colleagues.

**I hereby acknowledge receipt, agreement and understanding of all of the above guidelines and agree to enter into psychotherapy under the care of . I further understand that I may revoke this consent at any time. (Please sign and date below)**

_____

PRINT NAME HERE

_____ _____

CLIENT SIGNATURE DATE