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: 9:30 AM – 6 PM, closed daily from 12:30 PM – 1 PM

Our Castro clinic location is open
Monday: 9:30AM – 6PM, closed from 12:30 PM – 1 PM
Tuesday: 1PM – 6PM, closed from 12 PM – 1 PM
Thursday: 9:30AM – 5:30PM, closed from 12 PM – 1 PM

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.

Please give us a call at **415-292-3400** to schedule future appointments.

We currently accept Medi-cal, Anthem Blue Cross Medi-cal, San Francisco Health Plan, Beacon, Medi-care, Aetna, HealthNet, and the Healthy San Francisco Program. You are encouraged to contact your insurance provider if not listed here to ask if they will cover services at our clinic. Our staff will be happy to try to assist you with any questions or concerns you may have. We also offer a sliding fee scale program for individuals who are unable to obtain insurance. We will assist you with healthcare enrollment and eligibility.

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. 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

TENDERLOIN CLINIC LOCATION
726 Polk Street, 4th Floor, San Francisco, CA 94109 TEL 415-292-3400 FAX 415-292-3418

CASTRO CLINIC LOCATION
1800 Market Street, Suite 401, San Francisco, CA 94102 TEL 415-292-3400 FAX 415-292-3418

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Patient Demographic Form

Current First Name_____ **Last Name**_____ **Gender Pronouns**_____
(Current) (Current)

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 □ street □ shelter □ transitional/temporary housing
□ stabilization room □group home □ doubling up/couch surfing □ other:_____

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

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

Emergency Contact Name_____ **Contact Phone Number**_____ **Relationship**_____

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

Please check all that apply

Gender Identity	Gender at Birth	Sexual Orientation
□ Male	□ Male	□ Gay/Lesbian/Queer
□ Female	□ Female	□ Heterosexual/Straight
□ Trans-MTF	□ Intersex	□ Bisexual
□ Trans-FTM	□ Decline to state	□ Questioning
□ Intersex	□ Other-_____	□ Asexual
□ Decline to state		□ Unknown
□ Other-_____		□ Decline to state
		□ Other-_____

Marital Status	Number of dependents in household (including self)	Employment Status	Source of Income	Monthly Income
□ Single/Not married		□ Employed	□ Alimony/Child Support	
□ Divorced/Separated		□ Unemployed	□ Food stamps	
□ Live-in with partner		□ Student	□ General/Public Assistance	
□ Married		□ Decline to state	□ Housing/Rental Subsidy	
□ Domestic partner		□ Other-_____	□ Social Security	
□ Civil union			□ Retirement Pension	
□ Decline to state	_____		□ Social Security	_____
			□ Other-_____	

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Medical Insurance Status	Preferred Pharmacy
□ Uninsured □ Medi-Cal/Medicaid □ Medicare □ Healthy SF □ Private-_____ □ Other-_____	Name of Pharmacy_____ Address_____ Phone Number_____ Fax Number_____

Ethnicity		Race	Primary Language
□ Burmese	□ Malaysian	□ American Indian/Alaska Native	□ English
□ Cambodian	□ Mein	□ Asian	□ Cantonese
□ Chamorro	□ Samoan	□ Native Hawaiian/Pacific Islander	□ Mandarin
□ Chinese	□ Singaporean	□ Black/African American	□ Spanish
□ Fijian	□ South Asian	□ White/Caucasian	□ Tagalog
□ Filipino/a	□ Taiwanese	□ Latino/a	□ Thai
□ Hawaiian	□ Thai	□ Decline to state	□ Vietnamese
□ Hmong	□ Tongan	□ Other-_____	□ Other-_____
□ Indonesian	□ Vietnamese		
□ Japanese	□ West Asian		
□ Korean	□ Other Asian-_____		
□ Laotian	□ Other-_____		

Disabled	Migrant
□ Yes	□ Yes
□ No	□ No

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

SAN FRANCISCO COMMUNITY HEALTH CENTER

Adult Health Questionnaire

Patient Name _____ Pronouns _____

Legal Name _____ Today's Date _____

(name on legal documents, if different)

Date of Birth _____

What would you like to talk about with your healthcare provider about today?

_____

_____

Medical History

Do you have allergies to any medications? Yes ☐ No ☐

If yes, please list: _____

_____

_____

Have you ever had any of the following medical conditions?

	Migraine headaches		Heart attack		Thyroid problems
	Seizure		Heart failure		Depression
	Stroke		Problems with heart rhythm		Anxiety
	Eye problems		High cholesterol		Panic attacks
	Hearing problems		Blood clots		Other emotional or mental health concerns
	Asthma		Stomach ulcer		Substance use
	COPD or emphysema		Liver problems		Sexually transmitted infection (chlamydia, gonorrhea, syphilis, herpes)
	Tuberculosis (TB)		Hepatitis		Cancer
	High blood pressure		Kidney/bladder problems		Other:
	Diabetes		HIV infection		Other:

Have you ever had surgery or a medical procedure requiring anesthesia or sedation? Yes ☐ No ☐

If yes, please list below

Type of surgery/procedure	Location	Date

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Medications: Please list all medications that you are currently taking including prescription medications, vitamins, herbs and natural supplements. Please note the dose if possible.

Medication Name	Dose	Frequency (how many times/day)

When did you last see a healthcare provider? _____

Are you currently receiving care from any other health care professionals? *If yes, please list below.* Yes ☐ No ☐

Provider Name	Condition they are treating you for

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		

Do you have other concerns or things that you think are important for us to know about your health?

_____

_____

_____

San Francisco Community Health Center

CONSENT FOR SERVICES

A. CONFIDENTIALITY

As a client of San Francisco Community Health Center (SFCHC) the conditions of services have been explained to me to my satisfaction. I understand that records concerning my participation will be retained and that such information will be kept confidential according to federal (HIPAA) and state regulations. No information about me will be released to agencies or persons outside of SFCHC without my written authorization, except in case of a medical emergency, to secure payment for my treatment from a health insurance plan or other third party payment system, or as permitted by current law.

B. CONSENT FOR COMMUNICATION & FOLLOW-UP

I understand that it may be necessary for me to be contacted on an ongoing basis. If I am to be contacted by telephone, through mail, or email, no mention of any specific medical condition shall be made verbally or in writing unless I have given explicit verbal or written consent to do so. When phone messages are left, only the name and phone number of the caller from the program will be given. If translation services are needed for forms and appointments, they will be provided to me over the phone or in person.

I understand that I also consent to communications among SFCHC agency staff, other onsite service providers and treatment information (both medical and psychiatric or behavioral health related).

C. BILLING

I understand that APIWC will bill my insurance for services provided. If I do not have insurance, SFCHC will help evaluate and facilitate insurance enrollment through Medi-Cal, Covered California, Healthy San Francisco and/or the insurance marketplace. I understand I will also be evaluated on a sliding fee scale for services at The Wellness Clinic based on my ability to pay, but will not be turned away for lack of funds.

E. MINOR'S RIGHTS

I understand that if I am under the age of 18 years, I am entitled to access sensitive health services including: pregnancy testing and evaluation, STI screening/treatment, Mental Health Services and Drug/Substance abuse services without parental notification.

F. SERVICE ENROLLMENT

I understand that the following services offered by SFCHC are available for me to access. I agree to receive treatment for medical or behavioral health services from the agency, its staff, contracted health care professionals. I may also receive care from interns and students working under the supervision of health care professionals. I understand that by enrolling, I give consent to The SFCHC to review my prescription medication history to reduce any overprescribing or interaction risks.

I understand that the agency has a policy for resolving grievances and that I may request a copy of the grievance form at any time.

Client Signature: _____ Staff Signature: _____

Client Name (print):_____ Staff Name (print): _____

Date: _____

Note: Consent for Services is valid until revoked by client in writing

SAN FRANCISCO COMMUNITY HEALTH CENTER COMMUNITY AGREEMENTS

COMMUNITY COMMITMENTS

As a collective of clients and staff, we are committed to:

- Building and empowering communities
- Respecting ourselves, each other, and this space
- Ensuring the safety of all clients and staff
- Maintaining confidentiality

This is our safe space and we create it together every day

RULES AND REGULATIONS

San Francisco Community Health Center (SFCHC) provides a safe environment for clients and staff. All clients and staff are expected to treat each other with mutual respect.

The following behaviors will not be tolerated:

1. Violence or threats of violence, displaying weapons, or verbal harassment/intimidation of participants or staff.
2. Theft from participants, staff, of SFCHC.
3. Destruction or damage of property of participants, staff, or SFCHC.
4. Using or selling alcohol and/or illicit drugs at SFCHC.
5. Discrimination or mistreatment based on race, ethnicity, language, sexual orientation, gender identity, gender expression, surgery status, sex, health, mental health status, disability, history of drug use, age, occupation, immigration status, religion, or economic status.
6. Sexual conduct.
7. Camping, or hanging out, in the agency hallway or waiting room.
8. Eating outside of the designated eating area.
9. Using the drop-in space for personal storage. (The agency is not responsible for client belongings; leaving items unattended is done so at your own risk).
10. Inappropriate use of the bathrooms: Use is limited to 10 minutes.
11. Unattended companion/service animals. (Proof may be required).

This is not an exhaustive list; staff may restrict other inappropriate behavior at any time.

Violation of these Community *Rules and Regulations* may result in the suspension or termination of services. Clients exhibiting behaviors outlined in *1 through 11* will be asked to leave the agency and return when they are calm. If a client refuses to leave, security will be notified and the client will be escorted out of the agency and away from the premises.

Client Signature: _____ Date: _____

Printed Name: _____

Staff Signature: _____

San Francisco Community Health Center

CONSEQUENCES FOR VIOLATING COMMUNITY AGREEMENTS

Our goal is to encourage client to enjoy San Francisco Community Health Center (SFHCHC) and never be suspended from using services. However, if participants break any of the Community Agreements, they will receive a **WARNING** or **SUSPENSION OF SERVICES (SOS)*,** depending on the nature of the incident.

Description of Incident	**Consequences**
Violence or threats of violence	At least a 6-month suspension. Conditional re-entry.
Theft from participants, staff, or SFCHC	At least a 90-day suspension
Destruction or damage of property of participants, staff, or SFCHC	At least a 90-day suspension
Using or selling of alcohol and/or illicit drugs at or SFCHC	At least a 30-day suspension
Verbal harassment or intimidation of staff, participants, or other community members	Warning (first time) At least a 30-day suspension after
Discrimination or mistreatment based on race, ethnicity, language, sexual orientation, gender identity, surgery status, sex, health, mental health status, disability, history of drug use, age, occupation, immigration, or economic status	Warning (first time) At least a 30-day suspension after
Sexual conduct	Warning (first time) At least a 2-week suspension after
Other inappropriate behavior	Warning or SOS

*Note: suspension of services will officially begin after staff delivers suspension notice to client

Client Name_____ Staff Name_____

Client Signature_____ Date_____

Copy requested and received: □ YES □ NO

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Sliding Fee Discount Program Interest Form

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
SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES

In addition to this summary, the attached "Notice of Privacy Practice" describes in greater detail how health information about you may be used and disclosed at San Francisco Community Health Center (SFCHC) and your rights regarding the use of that information.

Please review this summary and the Full Notice carefully.

SFCHC Pledge: Employees of SFCHC, its affiliates and contract providers understand that information about you and your health/mental/behavioral health is personal. They are committed to protecting such information.

Who will follow the rules in this notice: SFCHC and contract provider employees, SFCHC affiliates must follow these rules.
You have the right to: (please see possible restrictions starting on page 2 in the Privacy Notice)
• Ask to see, read, and/or obtain a copy of your client record (charges may be necessary).
• Ask to correct information that you believe is wrong in your client record.
• Ask that your client information not be shared with certain individuals.
• Ask that your health information not be used for certain purposes; for example, research.
• Ask SFCHC to send copies of your client 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 SFCHC employees may contact you.
• Receive a paper copy of the full SFCHC Notice of Privacy Practices.

SFCHC may use and disclose your health information to improve your treatment and to insure the quality of care.
• To improve the quality of care you receive, client information may be shared by providers within SFCHC and between SFCHC and other agencies, public health departments where you also receive services and its contract providers — including health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
• See Page 3-4 in the "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 care provider or call the SFCHC Privacy Officer or the Program Manager in charge of the Department where you receive your service..

If you believe your privacy rights have NOT been maintained while receiving services at SFCHC, you may file a complaint with the SFCHC Privacy Officer or his/her designee or with the San Francisco Department of Public Health or with the Secretary of the U.S. Department of Health and Human Services.

You can also file a complaint with the San Francisco Department of Public Health, send the complaint to the San Francisco Department of Public Health Privacy Officer at 2789 25th St., San Francisco, CA 94110, or call (415) 206-2354. To file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

I acknowledge receipt of SFCHC "Notice of Privacy Practices." I understand that my signature does not authorize disclosure, but only acknowledge that I have received a copy of the full Notice.

Patient/Client Signature: _____ Date: _____

Printed Name: _____

Relation (if other than patient): _____

If Patient/Client declined to sign receipt:

Staff Signature: _____ Staff Printed Name: _____

Date: _____

If Patient/Client is unable to sign:

Witness Signature: _____ Witness Printed Name: _____

Reason unable to sign: _____

Interpreter Signature: _____ Printed Name: _____

Date: _____