UCSF Health

Terms and Conditions of Registration, Medical Services, and Financial Agreement

UCSF Health Medical Foundation (UHMF) is part of the University and is comprised of its hospital(s), medical center(s), its hospital-based clinics, and the UCSF School of Medicine.

MEDICAL CONSENT: I consent to medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of treatment-related photographs, videotaping, laboratory procedures, and hospital services rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. To facilitate my care, I consent to evaluation and examination by a physician or other health team professionals who may be physically distant from me via telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies as determined by my providers. I also consent to my admission to the UCSF Health Medical Foundation if this is necessary for my care

RELEASE OF MEDICAL INFORMATION: The State of California Information Practices Act requires UHMF to provide the following information to individuals who supply information about themselves. As a patient of UHMF, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history, and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UHMF is authorized to maintain this information. As required by UHMF, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. UHMF will obtain my written authorization to release information about my medical treatment, except in those circumstances when UHMF is permitted or required by law to release information (see UHMF's Notice of Privacy Practices for a description of the specific circumstances under which UHMF may release this information). For example, UHMF may release a copy of my patient record to health care providers, health plans, governmental agencies, and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, UHMF is required by law to report my diagnosis to the State Department of Health Services.

FINANCIAL AGREEMENT: I understand that even if I have insurance, I may be financially responsible for some or all my medical services. For instance, if I have a co-pay, co-insurance, or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay UHMF for professional and clinical services. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements, and/or charity care. I also understand that when this agreement is signed by my spouse, parent, or a financial guarantor, my spouse, parent, or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs, and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.

ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS): I authorize and direct payment to UHMF of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UHMF, including emergency services, at a rate not to exceed UHMF actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UHMF by me.

I have read, agreed to, and received a copy of this Terms and Conditions of Service:

Printed Patient Name	**Today's Date**
Signature of Patient or Witness (required if patient unable to sign)	**Today's Date**
Witness Relationship to Patient	
Signature of Interpreter (if applicable)	**Today's Date**
Language Used	