



Santa Cruz Women's Health Center, 250 Locust St. Santa Cruz, California 95060 T. 831.427.3500

**Dear SCWHC Patient,**

**Thank you for choosing us as your provider and Welcome.**

The Women's Health Center began in 1974 as a small, non-profit feminist health collective, with a focus on women's reproductive health and advocacy. Although we have grown in size and sophistication, we remain true to our roots as a **Feminist** health center. We strive to provide high quality medical care and advocate for feminist issues and progressive policies regarding access to health care.

The SCWHC is a **non-profit** health center. One of our primary missions is to provide access to quality health services to all women and children, regardless of ability to pay or insurance status. Because we provide free and discounted care, and because we enroll patients in government programs that do not reimburse well, our income from the patient care we provide does not cover our expenses. So we depend on donations and grants to keep our doors open. Every penny we take in goes to pay for the cost of operating the health center.

If you do not have insurance, we will try to get your visit covered by one of several local, state or federal programs. For this reason, we ask everyone about things like employment status, what their living situation is, and what their personal and household income is. Some patients will not be eligible for any programs, and we must use your income level to determine how much of a discount you qualify for. We can set up payment plans and other arrangements, and occasionally, we can waive fees entirely. Our continued operation depends on patient contributions to the cost of their health care.

### **APPOINTMENTS:**

The appointment time you are given is when we need you to come in the front door. After you **REGISTER**, you will be seen by a **MEDICAL ASSISTANT** who will talk with you and measure things like your blood pressure, weight, etc. We are always striving to make the appointments as efficient as possible for our patients. Please be understanding if your provider falls behind, it is usually due to the need to attend to another patient who may have an urgent and complicated issue.

**If you cannot keep an appointment, PLEASE CALL** at least 24 hours before your scheduled appointment. We are very busy, and want to make the appointment available to another patient. Unless your insurance company does not allow it (Central Coast Alliance, for example), you will be charged \$20.00, if you do not cancel or reschedule at least 24 hours in advance.

### **YOUR PROVIDER:**

We try to assign every patient to one provider and will try to schedule all of your appointments with that provider. This provider is called your **Primary Care Provider**. This way you and your provider will get to know each other, which will result in better care for you. We encourage you to choose your primary provider, and, if you want to change providers, you can ask to do so at any time. If you have not been assigned a provider already and would like to pick one, please let us know. The

name of your provider will be associated with you in our computer system, so that inquiries and appointments can be directed accordingly.

### **PRESCRIPTIONS:**

If you need a medicine refilled, and the current prescription has no refills, please have your pharmacy fax us a request on your behalf. **DO NOT CALL US**, since we will just ask you to call the pharmacy. Please plan ahead and **allow at least a week** to get your refill done so that you do not miss any of your medicine.

### **AFTER-HOURS EMERGENCIES:**

If you have a medical emergency, such as a severe injury or possible heart attack, call 911 or go to your nearest emergency department.

If you have an urgent question or concern that cannot wait until we are open, please call our regular number (831-427-3500) or our answering service at: **1-800-668-7484**. The person on call will do their best to manage your issue, but may recommend that you go to the emergency department.

If you have to go to the emergency department, the providers there will see you and may contact our providers to discuss your problem. Please let them know you are a Santa Cruz Women's Health Center patient. If you need to be admitted to the hospital, we have a paid contract with physicians who specialize in hospital care. They will communicate directly with our providers about your care.

### **RESULTS OF TESTS AND DIAGNOSTIC STUDIES:**

- We will contact you as soon as is practical with any urgent results.
- We will contact you in a timely manner about any abnormal results.
- Unless you arrange otherwise with your provider, we will send you a blue card with your results.
- If you want to speak with a provider about your test results, please schedule an appointment for a minimum of *2 weeks after* the test is performed. If you do not schedule an appointment, the results will be reviewed with you at your next regular visit unless we call you to come in sooner.

### **CHILDREN IN THE CLINIC:**

We appreciate that it is sometimes difficult to find childcare for your children so that you can have a private visit with your healthcare provider. However, we cannot allow children under age 12 to sit unattended in the waiting room. If you are unable to arrange child care and must bring your children with you, you will need to take them into your visit with you. Thank you for your cooperation with this, and we will make every effort to work with you to schedule appointment times that are convenient.

Thank You!



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## Patient Registration Form

Please fill out this form completely and return to Front Desk to finish your Registration.

### DEMOGRAPHICS (please print)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security: \_\_\_\_\_  
 Gender:  Female  Male  Trans Female to Male  Trans Male to Female  Unknown  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security: \_\_\_\_\_

### CONTACT INFORMATION (please print)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
 Message OK? Yes/No Yes/No Yes/No  
 Email Address: \_\_\_\_\_  
 Primary Language Spoken: \_\_\_\_\_ Interpreter Needed?  Yes  No  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

### STATISTICS

Living Status Choose one ONLY	EPIC #	Race (Choose one more more)	Migrant Status Choose one	Ethnicity	Veteran Status
<input type="checkbox"/> Living in shelter	1	<input type="checkbox"/> Asian or Pacific Islander	<input type="checkbox"/> Migrant worker	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Veteran
<input type="checkbox"/> Living in transitional housing or group home	2	<input type="checkbox"/> Black (can be Latino/Latina)	<input type="checkbox"/> Seasonal worker	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Non-Veteran
<input type="checkbox"/> Living with others for LESS than 6 months	3	<input type="checkbox"/> Alaskan	<input type="checkbox"/> Neither	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Living on the streets	4	<input type="checkbox"/> American Indian			
<input type="checkbox"/> At risk of being homeless	7	<input type="checkbox"/> Hawaiian Native			
<input type="checkbox"/> I rent/own my own home/apartment	8	<input type="checkbox"/> White (can be Latino/Latina)			
<input type="checkbox"/> Currently NOT homeless but was in the past 12 months	5	<input type="checkbox"/> Unknown			

### Income/Family Information AFFIDAVIT (please print)

Family Size: \_\_\_\_\_ Total Household Income: \_\_\_\_\_  
 (you + dependents/spouse)  Monthly  Annually

I, \_\_\_\_\_ (print name) declare under penalty of perjury that the information I have given on this form is true, correct, and complete. I understand that giving false information may make me ineligible for sliding scale discounts, state programs, and may be asked to provide income verification.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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Place patient label here

## Registro del Paciente

*Por favor de llenar esta forma y entregarsela a la recepcionista.*

<b>INFORMACION PERSONAL</b>		
Nombre del paciente: _____ Fecha de nac.: _____ Seguro Social: _____		
Sexo: <input type="checkbox"/> Femenino <input type="checkbox"/> Masculino <input type="checkbox"/> Transexual Femenino a Masculino <input type="checkbox"/> Transexual Masculino a Femenino <input type="checkbox"/> No Sé		
Dirección (calle y número): _____		
Ciudad: _____ Estado: _____ Código postal: _____		
Nombre del padre/Responsable del menor: _____		Fecha de nac.: _____ Seguro social: _____

<b>MÉTODO DE CONTACTO</b>		
Teléfono de casa: _____ Teléfono de celular: _____ Otro número: _____		
¿Se puede dejar mensaje? Sí / No	Sí / No	Sí / No
Correo electronico: _____		
Lenguaje que se habla en casa: _____		¿Necesita intérprete? <input type="checkbox"/> Sí <input type="checkbox"/> No
Contacto de emergencia: _____		Teléfono: _____ Relación: _____

<b>ESTADÍSTICAS</b>					
Estado de hogar Elija uno	EPIC #	Raza (Elija uno o más)	Estado migratorio  Elija uno	Grupo étnico	Es Usted Veterano?
<input type="checkbox"/> En riesgo de quedar sin hogar	1	<input type="checkbox"/> Isleño asiático o del pacífico	<input type="checkbox"/> Trabajador migrante	<input type="checkbox"/> Hispano	<input type="checkbox"/> Veterano
<input type="checkbox"/> Viviendo en un refugio	2	<input type="checkbox"/> Negro (puede ser latino/latina)	<input type="checkbox"/> Trabajador temporal	<input type="checkbox"/> No Hispano	<input type="checkbox"/> No Veterano
<input type="checkbox"/> Viviendo con otros menos de 6 meses	3	<input type="checkbox"/> Nativo de Alaska	<input type="checkbox"/> Ninguno de los dos	<input type="checkbox"/> Desconocido	<input type="checkbox"/> Desconocido
<input type="checkbox"/> Viviendo en la calle, el campo o debajo del puente	4	<input type="checkbox"/> Indio Americano			
<input type="checkbox"/> En un hogar transitorio (solo por el momento)	7	<input type="checkbox"/> Nativo de Hawaii			
<input type="checkbox"/> Yo rento/ tengo casa propia o departamento	8	<input type="checkbox"/> Blanco (puede ser latino/latina)			
<input type="checkbox"/> Actualmente no sin hogar pero estuve sin hogar en los 12 meses pasados	5	<input type="checkbox"/> Desconocido			

<b>INGRESOS / INFORMACION DE LA FAMILIA</b>	
Número de familia: _____ (usted y cuantas personas más viviendo y compartiendo gastos)	Ingreso total: _____ <input type="checkbox"/> Al mes <input type="checkbox"/> Al año
Yo, _____ (su nombre) declaro que la información que yo he dado en esta forma es verdadera, correcta, y completa. Comprendo que dando información falsa me puede hacer inelegible para descuentos, programas del estado, y que tendre que proveer información y verificación de mis ingresos.	
_____	_____
Firma	Fecha



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FULL LEGAL NAME: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name you like to use : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Person to notify in case of emergency:

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Address : \_\_\_\_\_  
Street City State Zip Code

**Patient Consent for Treatment**

*I consent to be examined at the Santa Cruz Women's Health Center. I understand that all treatments or diagnostic measures will be explained to me at the time of the exam or procedure. I also understand that, if necessary, Santa Cruz Women's Health Center staff will make referrals to a specialist for services not provided at the Center.*

*I give my consent to be examined by a physician assistant, a nurse practitioner or physician. Physician assistants and nurse practitioners are certified and licensed to provide care under the supervision of a physician.*

Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
signature

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
signature

**Patient Consent for the Use and Disclosure of Health Information**

The Santa Cruz Women's Health Center is committed to treating and using protected health information about you responsibly by obeying laws on how we use and share your information. We are required to obtain your consent for the use and disclosure of health information:

*I give my consent to the Santa Cruz Women's Health Center to use and disclose my health information for treatment, payment, and health care operations.*

*I acknowledge that I have been advised of my right to:*

- *Review the SCWHC Privacy Notice*
- *Request restrictions on how information is used and disclosed for treatment, payment and health care operations purposes*
- *Revoke consent*

*I acknowledge that I have received the Notice of Privacy Practices of the Santa Cruz Women's Health Center and I have been provided an opportunity to review it.*

Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
signature

# Santa Cruz Women's Health Center

## CONFIDENTIAL HEALTH HISTORY – NEW PATIENT ADULT (AGES 21 and over)

\_\_\_\_\_  
Your Name (last, first)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Your birth date

Main purpose of today's visit: \_\_\_\_\_

Other concerns: \_\_\_\_\_

### MEDICATIONS/HERBS SUPPLEMENTS

Please list all medicines and supplements that you take (include herbs, vitamins, birth control pills, etc)

Medication	Dosage (mg/pill – if you know it)	How many times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies or reactions to medications: \_\_\_\_\_

### HABITS AND LIFESTYLE:

#### Medical Assistant Intake

How would you rate your diet?  Good  Fair  Poor

How many servings of fruits and vegetables do you eat per day? \_\_\_\_\_

How many sweetened beverages do you drink per day? \_\_\_\_\_

Do you exercise?  Yes  No

What kind of exercise? \_\_\_\_\_

How long (minutes)? \_\_\_\_\_ How often? \_\_\_\_\_

If you do not exercise, why? \_\_\_\_\_

Do you drink alcohol?  No  Yes If so, # drinks/week: \_\_\_\_\_

Cigarettes  Never  Quit Date \_\_\_\_\_

Current/ Former Smoker: # cigarettes/day? \_\_\_\_\_ # of years \_\_\_\_\_

If you are a current smoker, are you interested in quitting?

No  Yes

Do you use a birth control method?  No  Yes

If so, what method do you use? \_\_\_\_\_

Do you get at least 1000 mg of Calcium and 400 IU of Vitamin D daily in the form of milk, dairy products, or supplements?  Yes  No

#### Menstrual History

Do you have menstrual periods?  Yes  No

If so, what was the date of your last menstrual period? \_\_\_\_\_

If you have periods, are they regular?  Yes  No

If you have stopped menstruating, do you have hot flashes or other symptoms of menopause?  No  Yes

Have you had any vaginal spotting (bleeding) after menopause?  No  Yes

#### Sexual History

Have you had any sexual contact in the past year?  No  Yes

If so, please answer questions below:

Number of sex partners in the last 12 months? \_\_\_\_\_

Current sex partner(s) is/are:  Both  Female  Male

How often do you use condoms?  Always  Sometimes  Never

Have you had a new sexual partner(s) in the last 6 months?  No  Yes

Does your partner have other sexual partner(s)?  No  Yes

Do you feel you've ever been abused or used sexually?  No  Yes

Have you ever been raped?  No  Yes

Have you ever traded sex for money or drugs?  No  Yes

#### Safety

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed, or hopeless?  No  Yes

Do you see a dentist regularly?  Yes  No

Do you brush your teeth at least 2 times per day?  Yes  No

Do you floss your teeth regularly?  Yes  No

Do you wear sunscreen?  Yes  No

Are you in a relationship in which you have been physically hurt or threatened by your partner?  No  Yes

Have you ever been hit, slapped, or physically hurt or threatened by someone?  No  Yes

Who? \_\_\_\_\_

Do you use seatbelts consistently?  Yes  No

Do you have a gun in your home?  No  Yes

Do you use a helmet if you bike or skate?  Yes  No  NA

Has a family member or contact had a positive PPD test? (test screening for exposure to tuberculosis)  No  Yes

Have you had a known exposure to TB?  No  Yes

Do you ever make yourself vomit after you eat or do you take laxatives?  No  Yes

Do you use any recreational drugs?  No  Yes

If so, list: \_\_\_\_\_

Have you ever used needles to inject drugs?  No  Yes

Is your drug or alcohol use a concern for you or others?

No  Yes If yes, please explain: \_\_\_\_\_

**MEDICAL HISTORY:** please indicate whether you have had any of the following medical problems (with dates):

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies? To what? _____                        | <input type="checkbox"/> Liver disease/ hepatitis                               |
| <input type="checkbox"/> Cancer, what type? _____ Date diagnosed: _____   | <input type="checkbox"/> Kidney disease, what type? _____                       |
| <input type="checkbox"/> Diabetes, what type? _____ Date diagnosed: _____ | <input type="checkbox"/> Asthma/ other lung disease                             |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Skin problems/ what type? _____                        |
| <input type="checkbox"/> High Cholesterol                                 | <input type="checkbox"/> Frequent urinary tract/bladder infections?             |
| <input type="checkbox"/> Thyroid Problem                                  | <input type="checkbox"/> Gonorrhea, syphilis, herpes, warts, Chlamydia (circle) |
| <input type="checkbox"/> Heart Disease, what type? _____                  |   |

**HEALTH MAINTENANCE:** (Please list the date if you have had this test or vaccine)

- |  |   |
|--|---|
| Last cholesterol test _____ Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A _____ Hepatitis B _____ MMR _____ |
| Colonoscopy _____ Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No           | Tdap or Td (circle) _____ Meningitis _____    |
| Mammogram _____ Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No             | Flu shot _____ Pneumovax (pneumonia) _____    |
| Pap Smear _____ Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No             | Varicella (chicken pox) shot or illness _____ |
| Bone Mineral Density _____ Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |

**Pregnancy History:** # Pregnancies \_\_\_\_ # deliveries \_\_\_\_ # abortions \_\_\_\_ # miscarriages

**SURGERIES/HOSPITALIZATION:** please list all operations including C-sections with dates, and hospitalizations

- Year: \_\_\_\_\_ Reason: \_\_\_\_\_  
Year: \_\_\_\_\_ Reason: \_\_\_\_\_  
Year: \_\_\_\_\_ Reason: \_\_\_\_\_

**FAMILY HISTORY:** Are you adopted?  No  Yes If so, answer the questions below only if you know of the history of your biologic relatives. Have your relatives had any of the following? If so, please check the box, note who has/had the condition (Parent, sibling, grandparent, uncle, children, etc). Also let us know if it is your mother or father's side of the family if applicable.

- |   |   |
|---|---|
| Who?  | Who?  |
| <input type="checkbox"/> Alcohol/drug abuse: _____  | <input type="checkbox"/> Cancer, what type? _____                 |
| <input type="checkbox"/> Bleeding or clotting disorder: _____   | <input type="checkbox"/> High blood pressure: _____               |
| <input type="checkbox"/> Heart attack/ disease: _____   | <input type="checkbox"/> Diabetes: _____                          |
| <input type="checkbox"/> High cholesterol: _____  | <input type="checkbox"/> Depression/suicide/mental illness: _____ |
| <input type="checkbox"/> Stroke: _____  | <input type="checkbox"/> Asthma/ COPD: _____                      |
| <input type="checkbox"/> Birth defect/genetic problems (such as: Sickle cell anemia, PKU, Tay Sachs, G6PD): _____ |   |
| <input type="checkbox"/> Other medical problems in your family: _____   |   |

**SOCIAL:** Occupation: \_\_\_\_\_ Years of education/highest: \_\_\_\_\_  
Marital Status: Single Partner/Married Divorced Widowed Other: \_\_\_\_\_  
Spouse/partner's name: \_\_\_\_\_ Number of children/ages: \_\_\_\_\_  
Who lives at home with you? \_\_\_\_\_

Have you completed a living will or durable power of attorney for health care?  Yes  No  
Do you want to discuss Advanced Directives today?  Yes  NO

**REVIEW OF SYMPTOMS** (please check any **current or recent** symptoms that you have)

- |   |   |  |   |  |
|---|---|--|---|--|
| <b>General</b><br>__ fever<br>__ chills<br>__ weight change<br>__ weakness<br>__ fatigue<br>__ night sweats | <b>Ears/Nose/Throat/Mouth</b><br>__ hearing loss<br>__ earache<br>__ sore throat<br>__ congestion<br>__ runny nose<br>__ trouble swallowing<br>__ ringing in ears | <b>Eyes</b><br>__ change in vision<br>__ pain<br>__ recent check?<br>when _____            | <b>Heart</b><br>__ chest pain<br>__ palpitations<br>__ shortness of breath<br>with activity   | <b>Genitourinary</b><br>__ painful urination<br>__ bloody urination<br>__ urinary incontinence<br>__ vaginal discharge<br>__ unusual vaginal<br>bleeding<br>__ sexual issues |
| <b>Skin</b><br>__ rash<br>__ new mole<br>__ skin infection  | <b>Psych</b><br>__ depression<br>__ anxiety<br>__ stress<br>__ sleep problems   | <b>Blood</b><br>__ bruising<br>__ unexplained lumps  | <b>Gastrointestinal</b><br>__ nausea or vomiting<br>__ blood in bowel movement<br>__ change in bowel movement<br>__ abdominal pain<br>__ constipation<br>__ heartburn |  |
| <b>Respiratory</b><br>__ cough<br>__ wheezing<br>__ coughing up blood                                       | <b>Neurologic</b><br>__ fainting<br>__ headache<br>__ memory loss<br>__ trouble taking care of yourself   | <b>Musculoskeletal</b><br>__ joint pain or swelling<br>__ recent back pain<br>__ neck pain | <b>Endocrine</b><br>__ increased thirst<br>__ cold/heat intolerance   | <b>Allergy</b><br>__ rash<br>__ hay fever<br>__ hives  |

**Patient Signature:** \_\_\_\_\_ **Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Santa Cruz Women's Health Center  
Notice of Privacy Practices  
Effective April 2003**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE SANTA CRUZ WOMEN'S HEALTH CENTER (SCWHC) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**What is this Notice and Why is it Important?**

This notice is required by law to inform you of how your health information will be protected, how the SCWHC may use or disclose your health information, and about your rights regarding your health information. If you have any questions about this notice, please contact SCWHC's privacy officer at 831-427-3500.

**Understanding your Health Information**

Each time you visit a physician, healthcare provider or hospital a record of your visit is made. Typically, this record contains a description of your symptoms, medical history, examination and test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care.
- Legal documents of the care you receive
- Means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed
- A data source for medical research and public health
- A source of data for planning facilities, marketing healthcare services, and fundraising
- A tool for educating health professionals
- A tool with which we can assess and work to improve the care we provide

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand how others may access and use your health information; and make more informed decisions when authorizing disclosures to others.

**Your Health Information Rights**

You have the following rights related to your medical and billing records kept by the SCWHC.

**Obtain a copy of this notice.** You will have the opportunity to review this notice at your first visit after its publication. Thereafter, you may request a copy of this notice or any revisions from the Front Desk or by calling 831-427-3500.

**Authorization to use your health information.** Before we use or disclose your health information, other than as described below, we will obtain your written authorization, which you may revoke at anytime to stop future use or disclosure.

**Access to your health information.** You may request a copy of your health information that the SCWHC keeps in your medical or billing record. Your request must be submitted in writing. We may charge for the costs of providing you access and for your copies.

**Amend your health information.** If you believe the information we have about you is incorrect or incomplete, you may request that we correct or add information. Your request must be in writing and you may request a form for this purpose by calling 831-427-3500.

**Request confidential communications.** You may request that when we communicate with you about your health information, we do so in a specific way (e.g. at a certain mail address or phone number). We will make every reasonable effort to agree to your request.

**Limit our use or disclosure of your health information.** You may request in writing that we restrict the use or disclosure of your health information for treatment, payment, health care operations, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or collect payment for our services.

**Accounting of disclosures.** You may request a list of disclosures of your health information that we have made for reasons other than treatment, payment or healthcare operations. Disclosures that we make with your authorizations will not be listed.

#### **Our Responsibilities**

We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our workforce and business associates, provide this notice about our privacy practices, and abide by the terms of this notice.

We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice. The new notice will be posted in the waiting room and will be available at the front desk.

Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at anytime. We are unable to take back any disclosure we have already made with your permission.

#### **Examples of Uses and Disclosures for Treatment, Payment and Healthcare Operations**

##### ***We will use your health information to facilitate your medical treatment.***

**For example:** Information obtained by a nurse or practitioner will be recorded in your record and used to determine the course of your medical treatment. We will also provide your practitioner or other healthcare providers involved with our treatment (e.g. specialists, consulting physicians, anesthesiologists, therapists, etc.) with copies of various reports that should assist them in treating you.

##### ***We will use your health information to collect payment for health care services that we provide.***

**For example:** A bill may be sent to you or your health insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. In some cases, information from your medical record is sent to your insurance company to explain the need for or provide additional information about your treatment.

##### ***We will use your health information to facilitate routine healthcare operations.***

**For example:** Members of our medical staff or quality improvement teams may use information in your record to assess the care you have received and how your progress compares to others. This information will then be used in efforts to improve the quality and effectiveness of the healthcare and other services we provide. We may use your health information to support necessary business, financial, and clinical functions. Examples of these functions may include: auditing our clinical procedures, analyzing our cost of care, arranging for patient satisfaction surveys, and determining the need for new healthcare services.

***We will use your health information to notify your family and friends about your condition.***

For example: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care or your general condition. Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, relevant health information to facilitate the person's ability to assist in your care or make personal arrangements for payment of your care.

***We may use your health information to inform persons about your death.***

For example: We may disclose health information to funeral directors, coroners, and medical examiners consistent with applicable law to carry out their duties.

### **Examples of Uses and Disclosures for Other Purposes**

***Appointment Reminders:*** We may contact you to provide appointment reminders.

***Alternative Treatments:*** We may use your health information to provide you with information about alternative treatments such as stress reduction.

***Marketing:*** We may use your health information to inform you about our healthcare services, treatment alternatives or other health-related benefits and services that may be of interest to you.

***Fundraising:*** We are a community-based, not-for-profit health center that may in the future develop fundraising activities. We may use limited information about you such as your name, address, demographic information, and the dates you received treatment information to inform you of opportunities to support the SCWHC and its services and programs.

***Research:*** We may contact you to request your participation in an authorized research study. If the study provides any type of healthcare treatment, the researcher will explain the benefits and risks of the treatment, how your health information will be used during the course of the study, and whether any of your health information rights are affected. You will need to authorize the use of your health information and agree to any suspension of your rights to participate in the study, however you may revoke this authorization at any time. In some cases, we may disclose your health information to researchers when an institutional review or privacy board has approved their research. Prior to giving any information, special procedures will be established to protect the privacy of your information.

***Worker's compensation:*** We may disclose your health information to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.

***Organ procurement organizations:*** Should you be an organ or tissue donor, we may disclose your donor status and health information to organizations engaged in the procurement, banking, or transplantation of organs, consistent with applicable laws.

***Public health:*** We may disclose your health information as required by law to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

***To avert a serious threat to health or safety:*** We may use and disclose your health information when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure would be made only to someone able to help prevent the threat.

***Correctional institution:*** Should you be an inmate of a correctional institution, we may disclose to the institution or their agents health information necessary for your health and the health and safety of other individuals.

**Law enforcement:** We may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order.

**Food and Drug Administration (FDA):** We may disclose to the FDA your health information relating to adverse events with respect to food, nutritional supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

**Business associates:** There are some services provided in our organization through contracts with business associates. Examples include transcribing your medical record, surveying for patient satisfaction, and a copy service we use when making copies of your health record. When these services are provided by contracted business associates, we may disclose the appropriate portions of your health information to our business associates so they can perform the job we have asked them to do. To protect your health information, however, we require all business associates to sign a confidentiality agreement verifying they will appropriately safeguard your information.

### **Special Situations**

**Military and Veterans:** If you are a member of the armed forces, we may disclose your health information as required by military command authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

**National Security and Intelligence Activities:** We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others:** We may disclose your health information to authorized officials so they may provide protection to the President and other governmental leaders, or conduct special investigations.

**Regulatory oversight:** We may disclose your health information to appropriate health oversight agencies, public health authorities or attorneys, when required by law. Your health information may also be disclosed if a workforce member or business associate believes in good faith that the SCWHC has engaged in unlawful conduct or has otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

### **For More Information, or to Report a Problem**

If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact the Privacy Officer at 831-427-3500.

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact SCWHC'S Privacy Officer. You may also send a written complaint to the U.S. Department of Health and Human Services at: 200 Independence Avenue, S.W. Washington, D.C. 20201. SCWHC will ensure that the care you receive at our facility will in no way be impacted if you file a complaint.