

Terms and Conditions of Registration, Medical Services and Financial Agreement

1. **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.
2. **MEDICAL CONSENT:** I consent to medical treatments or procedures x-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping and laboratory procedures.
3. **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 requested 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.
4. **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 clinic 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.
5. **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.
6. **CALLING/TEXTING/EMAILING:** I agree that UCSF Health may use an automated phone dialing system, pre-recorded or synthetic voice messages, texting, and email to contact me at the numbers and email address. addresses I provide. I understand that I may be contacted regarding my health care including, but is not limited to, appointment reminders, discharge planning, billing, prescription reminders, research opportunities, and/or to provide regulatory notice in lieu of first-class mail. I understand that when contacted in this manner, I will be given the opportunity to opt out of similar future communications. To learn more about opting out, visit: <https://www.ucsfhealth.org/billing-and-insurance>.
7. **NOTICE TO CONSUMERS:** Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to **www.mbc.ca.gov**, email: **licensecheck@mbc.ca.gov** or call **(800) 633-2322**. Nurse practitioners are licensed and regulated by the Board of Registered Nursing available at **(916) 322-3350** or **www.rn.ca.gov**
8. **CONSENT TO USE SCRIBE [AI] RECORDING DURING CLINICAL ENCOUNTER:** UHMF may use an application-based recording tool, e.g. Abridge, during your clinical visit to assist your healthcare provider with documenting your care. With your consent, portions of your conversation with your healthcare provider may be recorded and processed to create a transcript and assist with the preparation of clinical notes and other documentation for your medical record. Information generated from the recording may be reviewed and entered into your medical record in Epic. Once the recording has been transcribed and the necessary clinical documentation has been created, the recording is deleted in accordance with applicable UCSF Health policies. The recording is not retained as part of your permanent medical record.



I do not consent to being recorded.

Billing Acknowledgement

Understanding Your Preventive Physical Exam

Your annual preventive physical exam is designed to help keep you healthy through recommended screenings, vaccinations, and preventive care. During this visit, your provider reviews your health history, performs an age-appropriate physical examination, and discusses preventive health recommendations.

A preventive physical exam is intended for patients who are not seeking evaluation or treatment for a new or existing medical problem.

Preventive Physical Exam	Problem-Oriented Office Visit
Annual wellness/preventive care	Evaluation of new symptoms or illness
Review of medical/family/social history	Evaluation of chronic conditions
Preventive screenings	Diagnosis and treatment
Routine physical examination	Medication management
Preventive counseling	Diagnostic tests, imaging, referrals
Recommended immunizations	Follow-up care

Why Might I Receive Two Charges?

If both preventive care and evaluation/treatment of a specific medical concern are provided during the same appointment, your provider must document and bill them separately. Depending on your insurance plan, you may be responsible for additional out-of-pocket costs.

Patient Acknowledgement

I understand that:

- ☐ My preventive physical exam covers preventive services only.
- ☐ If I ask my provider to evaluate or treat a new or existing medical condition during today's appointment, an additional office visit may be billed.
- ☐ My insurance may apply copayments, deductibles, or coinsurance for problem-oriented services

Ophthalmology Consultation & Refraction Fee Notice

A visit with UHMF Pediatrics Ophthalmology is a specialist consultation, not a routine or annual eye exam. Your visit may be subject to your insurance deductible, co-insurance, or other out-of-pocket costs.

Refraction Fee

Refraction determines whether you need corrective lenses and is required to prescribe glasses.

Most insurance plans do not cover refraction. The fee is **\$68.00** and will be billed to your insurance first. Any unpaid balance is your responsibility.

Prescription Rechecks

If you have concerns about your glasses, please first contact your optical provider for verification.

If a prescription re-evaluation is needed:

- Rechecks within **60 days** of the prescription date are provided at **no charge**.
- Rechecks after **60 days** will be billed at the standard office visit rate.

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

Signature of Patient or of Patient Representative

Relationship to PT

Signature of Witness (required if patient unable to sign)

Relationship to PT

Signature of Interpreter

Language Used

Date of Signature: _____