UNIVERSITY OF CALIFORNIA
DAVIS HEALTH SYSTEM
NOTICE OF PRIVACY PRACTICE

ACKNOWLEDGEMENT OF RECIEPT:

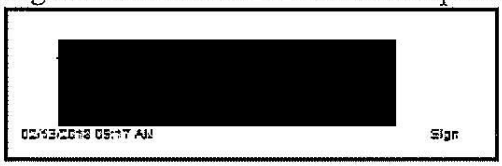
NOTICE OF PRIVACY PRACTICES

The UC Davis Health System Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we are providing you, copies of the current notice are available by accessing our Web site at http://www.ucdmc.ucdavis.edu/compliance/ and may be obtained throughout UC Davis Health System.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative



Date of Signing: 2/13/2018

Print Name

Relationship to Patient

Interpreter (If applicable)

Written Acknowledgement Not Obtained

Please document your efforts to obtain acknowledgment and reason it was not obtained.

☐ Notice of Privacy Practices Given – Patient Unable to Sign

☐ Notice of Privacy Practices Given – Patient Declined to Sign

☐ Notice of Privacy Practices Mailed to Patient – Awaiting Signature

☐ Other Reason Patient Did Not Sign

Signature of UC Davis Health System Representative

Date of Signing: 2/13/2018

Print Name

Department

70000-789 (1/13) **ACKNOWLEDGEMENT OF RECIEPT: NOTICE OF PRIVACY PRACTICES**

UNIVERSITY OF CALIFORNIA
DAVIS HEALTH SYSTEM
TERMS AND CONDITIONS OF SERVICE

1. UCDHS: The UC Davis Health System (UCDHS) is part of the University of California and is comprised of the UCDHS Medical Center and its hospital-based clinics, the Primary Care Network clinics, the UCDHS Medical Group, and the UC Davis School of Medicine.

2. MEDICAL CONSENT: I consent to any medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, telehealth services, taking of medical photographs, videotaping, laboratory procedures, and hospital services (except for those which require special consent) rendered to me under the general and special instructions of the attending physicians, or other physicians of UCDHS assisting in my care.

3. ADMISSION TO THE HOSPITAL: I also consent to my admission to UCDHS Medical Center if this is deemed necessary for my care. All of the terms and conditions of this agreement shall also apply to such admission.

4. TEACHING, RESEARCH AND HEALTHCARE INSTITUTION: The University of California, including UCDHS, is a teaching, research and healthcare institution. I understand that medical residents, medical students, students of ancillary health care professions (e.g., nursing, x-ray,rehabilitation therapy), post-graduate fellows, and other trainees may observe, examine, treat or otherwise participate in my care at the request and under the supervision of my health care provider as part of the University's medical education programs. I understand that my health information may be used and shared with researchers who engage in research, teaching and study related to my treatment, health condition, specimens and/or medical or physical status. Additionally, as a result, potentially commercially useful products may be developed and I understand that I will have no ownership rights in those products. Any use of my medical information and/or specimens by UCDHS or other institutions will be in accordance with state and federal law, including all laws and regulations governing confidentiality of patient records.

5. RELEASE OF INFORMATION: UCDHS will obtain my written authorization to release information about my medical treatment, except in those circumstances when UCDHS is permitted or required by law to release information (see UCDHS' Notice of Privacy Practices for a description of the specific circumstances under which UCDHS may release this information). For example, UCDHS may release a copy of my patient record to other health care providers, health plans and government agencies. Additionally, I understand that if I am diagnosed with cancer, a reportable disease in California, UCDHS is required by law to report my diagnosis to the State Department of Health Services.

6. PERSONAL VALUABLES: UCDHS maintains fireproof safes for the safekeeping of money and valuables. UCDHS shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs or other articles of unusual value and shall not be liable for loss or damage to any personal property, unless deposited in UCDHS' safe or locked storeroom. The liability for loss of any personal property deposited with UCDHS shall be no more than $500.00.

7. USE AND DISCLOSURE OF MEDICAL INFORMATION: The California Information Practices Act requires UCDHS to provide the following information to individuals who supply information about themselves: As a patient of UCDHS, you will be asked to submit information about yourself, such as your address and phone number, Social Security number, insurance information, medical history and treatment, and other personal information. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care.

University policy, California and federal law and regulations authorize the maintenance of this information. Furnishing all information requested is mandatory unless otherwise noted. Failure to provide such information may affect your medical care and/or insurance benefits and coverage. The information you provide may be disclosed to others, however, you have the right to review your medical information and the right to request restriction of access to your medical information, as described in the Notice of Privacy Practices. If you would like your agent under a durable power of attorney for health care or your next of kin to receive a copy of your rights and responsibilities as a patient of UCDHS (Notice of Privacy Practices & Patient Rights and Responsibilities Notice), please contact the Health Information Management Department at (916) 734-5205.

8. FINANCIAL AGREEMENT: I agree to pay The Regents of the University of California for professional, hospital and clinic services, including UCDHS physician services, in accordance with the Charge Master in effect on the date of service. I also agree to pay for other professional services provided by other physicians at UCDHS. Should the account be referred to an attorney or collection agency for collection, I agree to be responsible for all collection fees (attorney's fees, costs and collection expenses) in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection also bear interest at the then current legal rate.

9. ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS): I authorize and direct the payment to UCDHS of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UCDHS services, including emergency services, at a rate not to exceed those in the Charge Master in effect on the date of service. 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 UCDHS by me.

10. NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California. For information or complaints regarding medical doctors, you may contact the Medical Board of California at (800) 633-2322 and/or online at www.mbc.ca.gov.

Physician Assistants are licensed and regulated by the Physician Assistant Committee. For information or complaints regarding physician assistants, you may contact the Physician Assistant Committee at (916) 561-8780 and/or online at www.pac.ca.gov.

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

Signature of Patient	Signature of Patient's Representative	Date of Signing:
		2/13/2018

Re[redacted]e to Patient 05:18 AM Sign

Signature of Interpreter

Date of Signing: 2/13/2018

Signature of Witness (required if patient unable to sign)

Date of Signing: 2/13/2018

For office use only:

EXCEPTIONAL SIGNATURE REQUIREMENTS ARE REFERENCED BELOW. Please check the appropriate box.

☐ **PATIENT IS LEGALLY INCOMPETENT TO SIGN:** The court approved guardian or conservator, the agent under an Advance Directive, or family member or other appropriate surrogate must sign as "Patient's Representative."

☐ **PATIENT IS PHYSICALLY INCAPABLE OF SIGNING:** The patient should give verbal consent, witnessed by a UCDHS employee. The Patient's Representative should sign in witness of the patient having given verbal consent. The UCDHS employee witness shall also sign.