UCLA Health System

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

☐ **WESTWOOD CAMPUS** ☐ **SANTA MONICA CAMPUS** ☐ **NPH CAMPUS**

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

1. **UCLAHS**: UCLA Health System (UCLAHS) is part of the University of California and is comprised of its hospital(s), medical center(s), its hospital-based clinics, its Primary Care Network clinics, the UCLA Medical Group; and the David Geffen 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, 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. I also consent to my admission to the UCLA Medical Centers if this is necessary for my care.

3. TEACHING, RESEARCH AND HEALTHCARE INSTITUTION: The University of California including UCLAHS, is a teaching, research and healthcare institution. I understand that residents, interns, 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, and participate at the request and under the supervision of the attending physician in my care as part of the University's medical education programs. Some UCLAHS faculty are identified by their name badge as "Visiting Professors". These faculty members do not have a California license, but are licensed in another state or country. These physicians are permitted to practice medicine in California under a special program developed by the Medical Board of California.

I also understand that a University institutional review board approves projects conducted by University researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

4. USE OF MEDICAL INFORMATION AND SPECIMENS: I understand that my medical information, photographs, and/or video in any form may be used for other UCLAHS purposes, such as quality improvement, patient safety and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that UCLAHS may collect during the course of my treatment and care may be used and shared with researchers. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research. I further understand that any use of my medical information or Specimens by UCLAHS or other research institutions will be in accordance with state and federal law, including all laws and regulations governing patient confidentiality, in the manner outlined in the UCLAHS Notice of Privacy Practices.

5. PERSONAL VALUABLES: UCLAHS maintains fireproof safes for the safekeeping of money and valuables. UCLAHS 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 a safe or locked storeroom. The liability for loss of any personal property deposited with UCLAHS shall be no more than $500.

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6. RELEASE OF MEDICAL INFORMATION: The State of California Information Practices Act requires UCLAHS to provide the following information to individuals who supply information about themselves. As a patient of UCLAHS, 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, UCLAHS is authorized to maintain this information. As required by UCLAHS, 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.

UCLAHS will obtain my written authorization to release information about my medical treatment, except in those circumstances when UCLAHS is permitted or required by law to release information (see UCLAHS' Notice of Privacy Practices for a description of the specific circumstances under which UCLAHS may release this information). For example, UCLAHS 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, including but not limited to cancer, HIV, tuberculosis, and viral meningitis, UCLAHS is required by law to report my diagnosis to governmental organizations such as the State Department of Health Services or the Center for Disease Control and Prevention.

7. FINANCIAL AGREEMENT: I understand that even if I have insurance. I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay 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 The Regents of the University of California for professional, hospital and clinic services, including UCLAHS physician services, in accordance with the regular rates and terms of UCLAHS. I also agree to pay for other professional services provided at UCLAHS by other health care providers. 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.

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8. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS)**: I authorize and direct payment to UCLAHS of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UCLAHS services, including emergency services, at a rate not to exceed UCLAHS 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 UCLAHS by me.

NOTICE TO CONSUMERS: Medical doctors, including your physician, are licensed and regulated by the Medical Board of California. For information you may call the Board at (800) 633-2322 or visit its website at http://www.mbc.ca.gov.

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

_____ or _____
Signature of Patient Signature of Patient Representative

_____
Signature of Witness (required if patient unable to sign)

_____
Relationship of Representative to Patient

_____ _____
Signature of Interpreter Language used

_____
Date of Signing Time of Signing

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 7) and Assignment Of Benefits (Including Medicare Benefits) (Paragraph 8) set forth above.

_____ _____ _____
Date Time Financially Responsible Party Witness

PATIENT RIGHTS NOTICE: (applies to inpatient admissions only)

Would you like your agent under a durable power of attorney for health care or your next of kin to receive a copy of the Patient Rights and Responsibilities Notice? If so, please contact the Patient Affairs Department at (310) 267-9113.

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ADVANCED DIRECTIVES:

I have an advance directive for health care (e.g., Power of Attorney for Health Care). Yes ☐ No ☐
I have provided UCLAHS with a current copy of my advance directive. Yes ☐ No ☐

If "No", I understand it is my responsibility to provide UCLAHS a current copy of my advance directive. If I want to express my health care wishes, I understand I should speak to my health care provider.

PRIVACY NOTICE - FINANCIAL AND MEDICAL RECORDS

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University Hospitals to provide the following information to individuals who supply information about themselves:

The principal purpose for requesting the information is to assure accurate identification and continuity of medical care, and payment therefore, from whatever source. University policy, California Administrative Code Title 22, Division 5, *Licensing and Certification of Health Facilities and Referral Agencies,* and federal statutes authorize our 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 any insurance benefits and coverage. This information may be provided: to your referring physician or other health care professionals involved in your medical care; to others to the extent required in connection with collection of accounts or a claim for aid, insurance or medical assistance to which you may be entitled; to University faculty and students for research and educational purposes; and may be released as provided by state and federal law. The privacy of your record will be safeguarded.

Individuals have the right to review their own records, in accordance with the Information Practices Act and University policy. Information on these policies can be obtained from the officials responsible for maintaining the information:

Your medical record is maintained by:

Westwood Campus
Department Head-Medical Records
UCLA Medical Center/Los Angeles, CA 90095
Phone: (310) 825-6021

Santa Monica Campus
Department Head-Medical Records
UCLA Medical Center/Santa Monica, CA 90404
Phone: (310) 319-4850

Your patient billing information is maintained by:

Westwood / Santa Monica Campuses
Department Head-Patient Accounts
UCLA Medical Center/Los Angeles, CA 90095
Phone: (310) 825-8021

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PRIVACY NOTICE - SOCIAL SECURITY NUMBER

The University system of records that requires the social security number was in existence and operating before January 1, 1975, under the authority of the Regents of the University of California. Article IX, Section 9, of the California Constitution. The disclosure is required by law or University procedure in effect prior to that date to verify the identity of the individual.

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your social security number is mandatory. It is used to verify your identity in the medical care, and payment system. Disclosure of the social security number is required pursuant to regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II, of the Social Security Act, as amended.

PRIVACY NOTICE - CANCER REPORTING

If, during your care at UCLA Medical Centers you have cancer diagnosed, UCLA Medical Centers must by State law (Chapter 841, Statutes of 1985) report this to the regional cancer registry. This information is being collected to help identify preventable causes of cancer, and includes specific details of the type of cancer and the treatment provided as well as information about you such as your name, age, sex, ethnicity, occupation, religion, address and social security number.

The information reported is confidential under California Health and Safety Codes, Section 211.3 and 211.5, and safeguards are in place throughout the system to ensure that your identity will not be unlawfully revealed. Some cancer patients may be contacted later by the California Department of Health Services or the regional cancer registries as part of their ongoing investigations into the causes of cancer.