UCLA Health

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

1. **UCLAH**: UCLA Health (UCLAH) 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 UCLAH, 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 UCLAH 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 UCLAH 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 UCLAH 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 UCLAH 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 UCLAH Notice of Privacy Practices.

5. PERSONAL VALUABLES: UCLAH maintains fireproof safes for the safekeeping of money and valuables. UCLAH 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 UCLAH shall be no more than $500.

UCLA Health

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

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

UCLAH will obtain my written authorization to release information about my medical treatment, except in those circumstances when UCLAH is permitted or required by law to release information (see UCLAH' Notice of Privacy Practices for a description of the specific circumstances under which UCLAH may release this information). For example, UCLAH 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, UCLAH 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 UCLAH physician services, in accordance with the regular rates and terms of UCLAH. I also agree to pay for other professional services provided at UCLAH 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. I understand that I will receive messages and calls on behalf of UCLA Health, at the numbers provided, including my cell phone number and e-mail address provided during my registration process. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

8. ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS): I authorize and direct payment to UCLAH of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UCLAH services,

including emergency services, at a rate not to exceed UCLAH 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 UCLAH by me. Patients insured by Part A of the Medicare Act (as primary payer): UCLA Health shall transfer title prior to use of any property (excluding fixed assets or equipment) furnished or supplied to its patient or other customer in connection with its medical services billed pursuant to Medicare Part A. Notwithstanding this title provision, patient accepts that the disposal of medical products or other supplies after used will be governed by UCLA Health handling and disposal protocols.

9. E-MAIL AND TEXTING CONSENT: I consent to having appointment reminders sent to me via texting with the understanding that I may opt out at any time. I understand that if I email or text UCLAH physicians and others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that that texting and email are not secure communication methods as unencrypted messages could be intercepted.

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.

ADVANCED DIRECTIVES:
An advance directive is a legal document that allows you to spell out your decisions about end-of-life care ahead of time and indicate who should speak for you if you cannot. It gives you a way to tell your wishes to family, friends and healthcare professionals and to avoid confusion later on. You may speak with your physician or a UCLAH staff member to understand how to obtain an Advance Directive.

I have an Advance Directive for health care (e.g., Power of Attorney for Health Care) Yes ☐ No ☐

I have provided UCLA with a current copy of my advance directive. Yes ☐ No ☐

If no, it is my responsibility to provide UCLAH with a current copy of my advance directive.

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.

UCLA Health

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

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: (424) 259-8045

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

PRIVACY – 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.

UCLA Health

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF SERVICE
CONFIDENTIALITY OF INFORMATION

ADMISSION AND MEDICAL SERVICES AGREEMENT – READ CAREFULLY BEFORE SIGNING

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.

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.

_____ _____ _____ ☐ AM ☐ PM
Signature of Patient or Patient Representative | Date | Time

_____
Relationship of Representative to Patient

_____ _____ _____ ☐ AM ☐ PM
Signature of Witness (Required if patient unable to sign) | Date | Time

_____ _____ _____ ☐ AM ☐ PM
Signature of Interpreter | Date | Time

_____ _____
Interpreter ID # | Language Used

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.

_____ _____ ☐ AM ☐ PM _____
Date | Time | Financially Responsible Party

_____
Witness

UCLA Health

PATIENT PROTECTION AND THE AFFORDABLE CARE ACT SECTION 1557

Discrimination is Against the Law

UCLA Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UCLA Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UCLA Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Office of the Patient Experience at (310) 267-9113.

If you believe that UCLA Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Office of the Patient Experience by mail at: 757 Westwood Plaza, Suite 1107 Los Angeles, CA 90095, by phone at: (310) 267-9113 or TTY: (310) 267-3902, by fax at: (310) 267-3613, or by email at: patientexperience@mednet.ucla.edu. If you need help filing a grievance, the Office of the Patient Experience is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

UCLA Health

PATIENT PROTECTION AND THE AFFORDABLE CARE ACT SECTION 1557

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (310) 267-9113 (TTY: 310-267-3902)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (310) 267-9113 (TTY: 310-267-3902)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (310) 267-9113 (TTY: 310-267-3902)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (310) 267-9113 (TTY: 310-267-3902)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (310) 267-9113 (TTY: 310-267-3902) 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (310) 267-9113 (TTY (հեռատիպ)՝ 310-267-3902)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. تماس بگیرید (310) 267-9113 (TTY: 310-267-3902) با

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (310) 267-9113 (телетайп: (TTY: 310-267-3902)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(310) 267-9113 (TTY: 310-267-3902) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل (310) 267-9113 (TTY: 310-267-3902) والبكم الصم هـ: رقم .

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ, ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ. ਕਾਲ (310) 267-9113 (ਟੀ ਟੀ ਵਾਈ: 210-267-3902)

UCLA Health

PATIENT PROTECTION AND THE AFFORDABLE CARE ACT SECTION 1557

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (310) 267-9113 (TTY: 310-267-3902) ។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (310) 267-9113 (TTY: 310-267-3902)

ध्यान दें: यदि आप किसी अन्य भाषा बोलते, सहायता सेवाओं, नि: शुल्क, आप के लिए उपलब्ध हैं। (310) 267-9113 कॉल (TTY: 210-267-3902)

ียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (310) 267-9113 (TTY: 310-267-3902).