



University HealthCare Alliance

Please read this document carefully. University HealthCare Alliance requires the Terms and Conditions of Service to be signed in its entirety, on an annual basis, without alteration.

1. **TERM OF AGREEMENT.**

I understand that the terms and conditions in this outpatient agreement will remain in effect for one year from the date of signature and that I will be asked to sign this agreement annually. I understand I will be asked to confirm that my demographic and insurance information is correct at each clinic visit. If my insurance or demographic information has changed, I will inform the clinic staff.

2. **MEDICAL CONSENT.**

I, the undersigned patient or legal representative, consent to the general treatment and procedures that may be performed. These procedures may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures provided to the patient under the general and special instructions of the patient's physician or surgeon. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care.

3. **TEACHING INSTITUTION.**

University HealthCare Alliance is affiliated with Stanford Health Care, which is a teaching facility, training physicians, surgeons, nurses, and other health care personnel. At the request, and under the supervision, of the attending physician, that residents, interns, medical students, post-graduate fellows and other health care personnel in training may participate in the care of the patient as part of their medical program.

4. **PHOTOGRAPHY.**

I consent to the taking of pictures, videos, or other electronic reproductions of the patient, including of their medical or surgical condition or treatment, and the use of the pictures, videos or electronic reproductions for purposes permitted by law. I consent to the evaluation and examination by a physician or other health team professionals who may be physically distant from me via virtual technologies, including but not limited to two-way video, digital images, and other virtual technologies as determined by my providers. I understand that my digital image in any form may be used for Stanford Medicine purposes, such as treatment, quality improvement, patient safety, education and security. Under specific circumstances and as required by law, I may be asked for a separate consent prior to the taking of pictures, videos or other electronic reproductions and the use or disclosure of those pictures, videos, or electronic reproductions. If the image is being used for research purposes and could be directly used to identify the patient, I will be asked for authorization to use or disclose the image as required by law. I understand that under California law I may not photograph, film or record any image of or conversation with a UHA employee or physician or another UHA patient without the explicit consent of all parties involved and that violation of this law may result in criminal or civil liability.

5. **FINANCIAL AGREEMENT.**

For the services to be rendered, I agree to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of University HealthCare Alliance. This includes financial responsibility for all deductibles and co-payments that may be required by the patient's insurance or health plan. This also includes services or supplies not covered by the patient's health insurance plan and/or Medicare. Should the patient's account(s) be referred to an attorney or a collection agency for collection, I further agree to pay actual attorneys' fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, paragraphs 6 (Contracted Health Plan Patients and Other Sources) and 7 (Assignment of insurance Benefits) will also apply.



Addressograph or Label – Patient Name, Medical Record Number

TERMS AND CONDITIONS OF SERVICE

6. CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES.

I understand that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which University HealthCare Alliance contracts, or through some other source (e.g. clinical trial sponsor, employer’s workers’ compensation insurance). I agree to be responsible under paragraph 5 (Financial Agreement) for paying the patient’s account: (a) if University HealthCare Alliance does not contract with the health plan; (b) for any co-payment and deductible; (c) for services not approved by the health plan or other source; (d) for services not covered and/or paid for by the patient’s health plan or other source to the extent allowed by law or contract.

7. ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).

I authorize direct payment to University HealthCare Alliance of any insurance benefits otherwise payable to or on behalf of the patient for services, at a rate not to exceed the actual charges. I understand and agree that I am financially responsible under paragraph 5 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, I further attest that information given to University HealthCare Alliance to assist the patient in applying for payment under Medicare is correct.

University HealthCare Alliance (“UHA”) is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA Contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.

The undersigned certifies that he/she has read the Terms and Conditions of Service, has received a copy of it, and is the patient or is duly authorized by or on behalf of the patient to execute and accept its terms.

PATIENT OR RESPONSIBLE PERSON SIGNATURE

RELATIONSHIP TO PATIENT

WITNESS SIGNATURE

DATE

INTEPRETER SIGNATURE

DATE

PRINT NAME

LANGUAGE

POSITION/RELATIONSHIP TO PATIENT

RELEASE OF INFORMATION

In compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), University HealthCare Alliance provides patient with a Notice of Privacy Practices, which describes how medical information about you may be used and disclosed, and how you can get access to this information. Additional copies of the Notice of Privacy Practices are available at any reception desk or registration office or by calling the University HealthCare Alliance’s Director of Compliance and Risk Management, at 510-731-2635.



**University HealthCare Alliance
Summary Notice of Privacy Practices**

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND/OR YOUR CHILD (“YOU”) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE HAVE ALSO PROVIDED YOU WITH A FULL VERSION OF THIS NOTICE.

Our pledge to protect your privacy:

University HealthCare Alliance (the “Clinic”) is committed to protecting the privacy of your medical information. Your care and treatment are recorded in a medical record. So that we can best meet your medical needs, we share your medical record with the health care providers involved in your care. We also share your business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

You have the following rights regarding your medical information:

- to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to add an addendum to or correct your medical record;
- to request an accounting of the Clinic’s disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information;
- to request that we communicate with you in a certain way or at a certain location; and
- to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions necessary to run the Clinic and assure that our patients receive quality care;
- to participate in research studies, subject to certain requirements; (for more detailed information please refer to the full Notice of Privacy Practices); and
- as required or permitted by law.

There are additional situations where we may disclose medical information about you without authorization, such as:

- for public health activities (e.g., reporting abuse or reactions to Medications);
- to a health oversight agency, such as the California Department of Health Services;
- in response to a court or administrative order, subpoena warrant or similar process;
- to law enforcement officials in certain limited circumstances;
- to a coroner, medical examiner or funeral director; and
- to organizations that handle organ, eye, or tissue procurement or transplantation.

Our Notice may be revised or updated from time to time. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices your rights regarding your medical information and pertinent contact information.

For further information about the full Notice of Privacy Practices, please contact the Director of Compliance and Risk Management at 510-731-2635.