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PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ___ / ___ / ___ Previous Name: _____ Cell Phone: _____

Home Phone: _____ Email: _____ Social Security #: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip Code: _____ County: _____

Marital Status *(choose one)*:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Language *(choose one)*:

☐ English ☐ Spanish ☐ Tagalog ☐ Other (Specify): _____

Special Assistance Needed:

☐ None ☐ Sign language ☐ Language Interpreter ☐ Other (Specify): _____

Preferred Contact Method *(choose all that apply)*:

☐ Phone ☐ Text Message ☐ E-mail ☐ Post Mail

Birth Sex *(choose one)*:

☐ Male ☐ Female

Sexual Orientation *(choose one)*:

☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual
☐ Other: _____ ☐ Choose not to disclose

Gender Identity *(choose one)*:

☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female
☐ Other: _____ ☐ Choose not to disclose

Race *(choose all that apply)*:

☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify): _____
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian/Chamorro
☐ Samoan
☐ Black/African American
☐ American Indian/Alaskan Native
☐ White
☐ Choose not to disclose

Ethnicity *(choose one)*:

☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Other Hispanic Latino/a or Spanish Origin
☐ Not Hispanic Latino/a or Spanish Origin

Are you homeless?

☐ Yes *(Select one of the following)* ☐ No

- O Shelter
- O Transitional Housing *(I live somewhere temporarily while I find permanent housing)*
- O Doubling Up *(I live with other people)*
- O Street
- O Permanent Supportive Housing *(Long-term stable housing with social services like social worker, case manager/worker)*

Agricultural Worker Status *(choose one)*:

☐ Migrant ☐ Seasonal ☐ N/A

Military Status: *Do you consider yourself a US Military Veteran?*

☐ Yes ☐ No

Primary Health Insurance

Insurance Company:_____ Plan (if applicable) _____

Group No.: _____ Subscriber ID: _____

Insured's Name (as it appears on insurance card or ID): _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Health Insurance

Insurance Company:_____ Plan (if applicable) _____

Group No.: _____ Subscriber ID: _____

Insured's Name (as it appears on insurance card or ID): _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Legal Guardian or Financial Party Responsible (if someone other than patient)

Last Name: _____ First Name: _____ Date of Birth: ___ / ___ / ___

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip Code: _____ Phone No.: _____

Relationship to Patient: _____ Social Security #: _____

Emergency Contact

Name: _____ Phone No.: _____ Relationship to Patient: _____

Signature of Patient/Legal Guardian: _____ **Date:** _____

Name of Patient/Legal Guardian: _____ **Relationship to Patient**:_____

Glossary

Agricultural Worker:

- Migratory agricultural workers: Individuals who work in agriculture and must keep traveling in different regions to have work.
- Seasonal agricultural workers: Individuals who work in agriculture on a seasonal basis and who DO NOT meet the definition of a migratory agricultural worker.

Ethnicity: Someone belonging to a population group/subgroup made up of people who share a common cultural background or descent, can be:

- Hispanic, Latino/a or Spanish Origin: Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban
- Not Hispanic, Latino/a or Spanish Origin
- Unreported/Choose not to disclose ethnicity

Homeless: Describes an individual who does not have safe and secure housing during the night in which the location is unfit for someone to live (e.g., street, field, abandoned building).

Homelessness Housing:

- Shelter: Typically offers a temporary place to sleep and food to those in need but often has limitations on the number of days or hours that a person can stay there.
- Transitional Housing: A housing solution that assists individuals into permanent housing.
- Doubling Up: Someone who is living with others. The arrangement is temporary and unstable,
- Street: Someone who is living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.
- Permanent Supportive: Is in service-rich environments, does not have time limits, and may be restricted to people with some type of disabling condition.
- Unknown: Someone who is known to be experiencing homelessness whose housing situation is unknown.

Military Status: Discharged individuals who served in the active military, naval, or air service, which includes the Air Force, Army, Coast Guard, Marines, Navy, and Space Force, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration. This also includes individuals who served in the National Guard or Reserves on active-duty status.

Race: A physical or social categorization of an individual that can be based on inheritance or genetics. Includes:

- Asian: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian
- Native Hawaiian/Other Pacific Islander: Guamanian or Chamorro/Samoan
- White/Caucasian
- Black/African American
- American Indian/Alaska Native
- More than one race
- Unreported/Choose not to disclose race

Sexual Orientation and Gender Identity (S.O.G.I):

- **Birth Sex**: Your sex at birth. (Male or Female)
- **Gender Identity**: How you feel about yourself as being a male/man or female/women and can be different than your birth sex.
    - Transgender (male to female): Male at birth who identifies as a female
    - Transgender (female to male): Female at birth who identifies as a male
- **Sexual Orientation**: How people describe their personal (emotional and physical) attraction to others.
    - Heterosexual: Men who are attracted to women and women who are attracted to men
    - Gay: Someone who is attracted to the same gender as themselves
    - Lesbian: Women who are attracted to other women
    - Bisexual: Someone who is attracted to women and men

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GENERAL PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

Patient Full Name: _____ **Date:** _____

Date of Birth: _____

This General Patient Consent and Acknowledgement Form provides information on Opsam Health's healthcare services and other notifications including, but not limited to, patient/parent or legal representative telehealth, privacy and health care record rights. Some notices below will require you to accept (check box with YES) or reject (check box with NO) the request.

By signing below, the patient/parent or legal representative consents to the health care as discussed below. Additionally, by signing below, the patient/parent or legal representative also acknowledges and agrees to other identified terms and conditions unless the patient/parent or legal representative elects the identified option to reject the request (check box with NO).

1. Consent to Care

By signing below, the patient/parent or legal representative understands and agrees that:

- Opsam Health provides primary care, preventive care, specialty care, behavioral health, and dental services.
- The patient's clinician will explain the patient's condition, recommended care, and important risks, benefits, and reasonable alternatives when needed. Patient/parent or legal representative can ask questions at any time.
- Patient/parent or legal representative may refuse or withdraw consent at any time. If recommended care is refused, the patient's clinician will explain potential risks of refusing.
- This is a general consent for evaluation and routine care, including immunization/vaccinations recommended by the Provider. Some procedures, medications, tests, dental treatment, behavioral health services, or other services may require a separate, specific consent or notice before they are provided.

2. Telehealth Appointments

Telehealth means receiving health care services using audio, video, or other electronic communication technology. If telehealth is chosen, by signing below, the patient/parent or legal representative understands and agrees that:

- Telehealth is not for emergencies. In an emergency, patient/parent or legal representative will call 911 or go to the nearest emergency room.

- Telehealth is voluntary. Patient/parent or legal representative can request an in-person visit instead and may withdraw consent to telehealth at any time.
- Before telehealth services are provided, the provider initiating telehealth will inform the patient/parent or legal representative about the use of telehealth and document the consent given as required by law.
- Telehealth may improve access and convenience, but it may have limitations compared with an in-person visit, such as technology problems or reduced ability to perform a physical exam.
- The patient's clinician may recommend an in-person visit or a higher level of care if telehealth is not appropriate.
- Patient/parent or legal representative will participate from a private location, when possible, to protect the patient's privacy. Telehealth visits will not be recorded without permission from the patient/parent or legal representative.
- At the start of a telehealth visit, patient/parent or legal representative may be asked to confirm the patient's identity and location. If the connection is disconnected, staff may call the patient/parent or legal representative back.

3. Financial Responsibility and Estimates

- Patient/parent or legal representative will provide complete and accurate insurance information and notify Opsam Health of changes. Patient/parent or legal representative authorizes Opsam Health to bill the patient's health plan and receive payment for covered services, when applicable.
- Patient/parent or legal representative is responsible only for amounts that may lawfully be billed under applicable law, payer rules, and provider contracts. These may include copays, deductibles, coinsurance, share-of-cost, or noncovered services when legally permitted and when any required notice or consent has been provided.
- Opsam Health will not bill the patient or responsible party for amounts that applicable law or payer rules prohibit billing, including Medicare cost-sharing for dual eligible/QMB patients when those protections apply.
- For Original Medicare patients, if Opsam Health believes Medicare may not pay for an item or service, Opsam Health will provide any required Advance Beneficiary Notice or other required notice before the service.
- If the patient is uninsured or chooses not to use insurance/self-pay, Opsam Health will provide a written Good Faith Estimate of expected charges when required by law, including when eligible services are scheduled or an estimate is requested.

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4. Privacy and Notice of Privacy Practices

- Opsam Health is committed to protecting the privacy of the patient's health information.
- Patient/parent or legal representative acknowledges receipt of Opsam Health's Notice of Privacy Practices (NPP). The NPP explains how Opsam Health may use and share the patient's information, the patient's privacy rights, Opsam Health's duties and how to file a complaint.
- Patient/parent or legal representative understands that a paper or electronic copy of the NPP may be requested at any time.
- If the patient/parent or legal representative declines or is unable to sign this acknowledgement, Opsam Health may document its good-faith effort to provide the NPP and the reason acknowledgement was not obtained.

5. Health Information Exchange (HIE) and Specially Protected Information

Health Information Exchange, such as San Diego Health Connect, helps participating organizations securely share health information to support patient care.

- Unless the Patient/parent or legal representative opts out below, the patient's health information may be made available through HIE to other participating organizations involved in the patient's care, as permitted by law.
- HIE sharing does not override laws that require additional consent or authorization, or that limit disclosure of specially protected information. Specially protected information may include, when applicable, substance use disorder treatment records, psychotherapy notes, reproductive health/abortion/contraception/gender-affirming care information, HIV/STI or communicable disease information, minor-consented services, genetic testing information, and other records protected by federal or California law.
- Even if the patient/parent or legal representative opts out, information may still be disclosed as required or permitted by law, including in emergencies or for certain public health, payment, or health care operations purposes.

☐ **Do NOT share the patient's health information through San Diego Health Connect/HIE at this time. Patient/parent or legal representative understands this decision can be changed later.**

6. Patient Portal and Electronic Communication

Opsam Health offers a secure Patient Portal for non-urgent messages. Opsam Health may send portal activation instructions unless the patient/parent or legal representative opts out below. If the Patient Portal is used, the patient/parent or legal representative understands and agrees that:

- The portal is for non-urgent communication. For emergencies, patient/parent or legal representative will call 911 or go to the nearest emergency room.
- Portal messages are not monitored 24/7. Opsam Health aims to respond within 3 business days.
- Portal messages may become part of the patient's medical record.
- Patient/parent or legal representative is responsible for keeping the portal login and password private. If the login is shared, others may access the patient's health information.
- Text messages, email, or other non-portal communications, if offered, may be handled through separate communication preferences or consents when required.

☐ **Do NOT provide Patient Portal access or activation instructions at this time.**

7. AI Scribe, Recording, and AI-Assisted Communications

Opsam Health clinicians may use a secure generative Artificial Intelligence (AI) documentation tool during visits if the patient/parent or legal representative consents (checks YES) below.

- AI is only used to help write notes and is not used for medical decisions. The patient's clinician is responsible for the patient's care. If the patient/parent or legal representative consents, the tool may process information from the patient's visit, create an audio recording or transcript for documentation, and generate a draft note to help the clinician document the patient's care. The clinician reviews, edits, and remains responsible for the final note.
- No visit audio recording will be created for this purpose unless the patient/parent or legal representative affirmatively consents. Any audio recording created for this purpose will be deleted within 7 days unless Opsam Health discloses a different retention period and obtains any required consent.
- In California, recording a confidential conversation generally requires the consent of all parties.
- If Opsam Health uses AI to prepare patient clinical communications in a way that requires patient notice, Opsam Health will include the required notice and contact instructions.

Choice for visit recording and AI-assisted documentation (check one):

☐ **Yes, patient/parent or legal representative consents to recording and AI-assisted documentation for medical record documentation purposes.**

☐ **No, patient/parent or legal representative does not consent to recording or AI-assisted documentation for medical record documentation purposes.**

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Patient/parent or legal representative understands that the decision to decline or accept can be changed at any time and that the patient's care will not be affected if consent is declined. If declined, the clinician will document the visit using standard methods.

8. Advance Health Care Directive

Patient/parent or legal representative has been informed that an Advance Health Care Directive is a legal document that allows the patient to state health care wishes and name someone to make decisions if the patient is unable to do so. Patient/parent or legal representative acknowledges the following:

Status of Advance Health Care Directive:

☐ Patient has an Advance Health Care Directive and would like Opsam Health to add it to the patient record. *(Please provide a copy to staff)*

☐ Patient/parent or legal representative would like information about Advance Health Care Directives.

☐ Patient does not have an Advance Health Care Directive and Patient/parent or legal representative does not request information about Advance Health Care Directives.

9. Minor Consent and Confidential Services

- In some situations, California law allows minors to consent to certain services on their own. In those situations, the minor's consent may be required, and the minor's authorization may be required before certain information is disclosed to a parent, guardian, or other person, unless disclosure is permitted or required by law.
- Portal proxy access, billing communications, appointment reminders, and records of requests may be limited or handled differently to protect confidential minor-consented services.

10. Acknowledgement of Additional Required Notices

Patient/parent or legal representative understands that Opsam Health may provide required notices and consent forms separately, electronically, on paper, by posting, or through the patient portal as permitted by law. These may include, when applicable:

- Notice of Privacy Practices
- Good Faith Estimate/No Surprises Act notices for uninsured, self-pay, or out-of-network services
- Language assistance, disability access, and nondiscrimination notices
- Service-specific notices and consents for dental, behavioral health, substance use disorder records, minor-consented services, reproductive health, procedures, medications, or other specially protected services

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This acknowledgement does not replace any full notice, authorization, or service-specific consent that is required by law or Opsam Health policy.

Signature

By signing, the patient/parent, or legal representative acknowledges that this form has been read and/or explained, that an opportunity to ask questions and receive a copy was provided, and that the terms and notifications are understood.

Signature: _____

Date: _____

Patient/Representative Name: _____

Relationship/Authority: _____

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INFORMED CONSENT FOR BEHAVIORAL HEALTH SERVICES

Patient Full Name: _____ **Date:** _____

Date of Birth: _____

Important

This service-specific consent applies only to Opsam Health behavioral health therapy services. It supplements the Consent and Notices for Health Care Services / Patient Acknowledgement and Consent and Opsam Health's Notice of Privacy Practices. Those general forms address general consent to care, telehealth terms, financial responsibility, privacy, Health Information Exchange, patient portal, AI scribe/recording choices, minor-consented services, and other notices that apply to all patients. This form is not a HIPAA authorization and does not authorize release of records or psychotherapy notes.

1. Behavioral Health Therapy Process

Opsam Health provides behavioral health therapy to help patients address mental health, emotional, relationship, behavioral, and life-stress concerns. Your therapist will work with you to identify treatment goals, develop a treatment plan, and review progress. Your input and feedback are important. You may ask questions and may agree or disagree with your therapist's recommendations.

Therapy may include assessment, individual or family sessions when appropriate, education, brief skills practice, care coordination, and referrals. The initial assessment is typically about 60 minutes. Follow-up sessions average about 30 minutes, and Opsam Health's brief therapy model often involves about 6 to 13 sessions. The length, frequency, and type of services may change based on clinical need, patient preference, provider recommendation, availability, and insurance or program requirements.

Therapy may help improve symptoms, coping skills, relationships, and functioning, but results cannot be guaranteed. Discussing difficult issues may at times temporarily increase sadness, anger, anxiety, confusion, or other distress. Your therapist may recommend a different provider, medication evaluation, community resource, group or program, higher level of care, or emergency service if your needs cannot be safely or effectively addressed through Opsam Health therapy services.

2. Behavioral Health Telehealth Services

Behavioral health therapy may be provided in person or by telehealth when clinically appropriate. Telehealth means receiving services through audio, video, or other electronic communication technology. The General Consent describes telehealth terms that apply to Opsam Health services generally; this section addresses behavioral-health-specific telehealth considerations.

- Telehealth may affect privacy, communication, and the therapeutic connection. Miscommunication, technology failure, interruptions, or difficulty hearing or seeing each other may occur.
- You should participate from a private, safe location where you can speak freely and are not driving or otherwise unable to focus safely on the session.
- At the start of a telehealth session, your therapist may confirm your full name, current physical location, phone number, and emergency contact so that emergency assistance can be requested if needed.

- Telehealth is not for emergencies or crisis stabilization. Your therapist may recommend an in-person visit, emergency evaluation, or higher level of care if telehealth is not clinically appropriate.
- This form does not authorize patient or provider recording of sessions or AI-assisted documentation. Any recording or AI-assisted documentation is handled only under the General Consent and any required separate or visit-specific consent.

3. Appointment Scheduling, Attendance, and Cancellations

Behavioral health sessions are typically scheduled once every other week at the same day and time when possible. Consistent attendance supports progress and continuity of care. Your therapist may recommend a different schedule or referrals depending on the nature and severity of your concerns.

Please notify Opsam Health at least 24 hours in advance if you need to cancel or reschedule. Three or more missed appointments or cancellations with less than 24 hours' notice may lead to review of your treatment plan and may be grounds for discontinuing therapy services if nonattendance prevents effective treatment. If therapy services are discontinued, Opsam Health will attempt to communicate with you and, when appropriate, provide referrals or resources.

4. Therapist Availability, Urgent Needs, and Emergencies

Important issues are usually best addressed during scheduled sessions. You may leave a message for your therapist or behavioral health care team using the contact method provided to you. Please clearly leave your name, callback number, brief reason for the call, and whether the matter is urgent. Messages, portal messages, and routine clinic communications are not monitored 24 hours a day, 7 days a week.

If you believe you or someone else may be in immediate danger, call 911 or go to the nearest emergency room. For mental health crisis support, call or text 988 or contact the San Diego Access and Crisis Line at 1-888-724-7240. For non-emergency community, health, or social service resources in San Diego, dial 2-1-1.

5. Confidentiality in Behavioral Health Therapy

Behavioral health communications are confidential under applicable federal and California privacy laws and Opsam Health privacy practices. The General Consent and Notice of Privacy Practices explain general uses and disclosures of health information, Health Information Exchange, patient portal communications, authorizations, and specially protected information. This section focuses on confidentiality expectations specific to behavioral health therapy.

Except as permitted or required by law, Opsam Health will not disclose your behavioral health therapy information outside Opsam Health and your involved care team without your written authorization. Your therapist may consult with supervisors or other Opsam Health clinicians as appropriate for treatment, care coordination, supervision, quality, or other permitted health care purposes.

Examples of situations where disclosure may be permitted or required by law include, but are not limited to:

- When there is a serious concern that you may pose a danger to yourself or others;
- Suspected abuse, neglect, or exploitation of a child, elder, dependent adult, or other person protected by law;
- A court order, subpoena, or other legal requirement;
- A medical or psychiatric emergency
- Treatment, payment, health care operations, or other disclosures permitted by law and described in Opsam Health's Notice of Privacy Practices.

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6. Treatment For Minors and Confidential Services

The General Consent addresses minor consent and confidential services generally. In behavioral health therapy, parents and legal guardians are often involved in a minor patient's care. At the same time, California law may allow a minor to consent to certain services and may require the minor's authorization before some information is shared with a parent, guardian, or other person, unless disclosure is permitted or required by law.

Your therapist will discuss confidentiality boundaries with the minor patient and parent or legal representative at the beginning of treatment and as appropriate during care. When permitted and clinically appropriate, the therapist may share general treatment progress, attendance, safety concerns, and treatment recommendations with the parent or legal representative. Specific therapy communications may be kept confidential when required or permitted by law. Safety concerns may require disclosure or emergency action.

7. Patient Participation and Safety During Sessions

Please attend sessions in a condition that allows you to participate safely and meaningfully. Do not attend a session while impaired by alcohol, cannabis, illegal drugs, non-prescribed controlled substances, or misuse of prescription or over-the-counter medications. This does not prevent you from discussing substance use or related concerns in therapy.

If your therapist determines that you cannot safely or meaningfully participate, the therapist may reschedule the session, recommend a different type or level of care, contact emergency support, or take other clinically appropriate steps.

8. Fees, Insurance, and Coverage Questions

Financial responsibility, insurance billing, and estimates are addressed in the General Consent and related notices that apply to all patients. Behavioral health coverage and benefits may vary by health plan, diagnosis, eligibility, service type, provider participation, and authorization requirements. Please contact your health plan about benefits and coverage questions. Opsam Health billing staff can answer clinic billing questions.

9. Complaints and Notice to Clients

Opsam Health takes patient concerns seriously. Patients may discuss concerns with their therapist, request to speak with a supervisor or clinic manager, or use Opsam Health's complaint or grievance process. This does not limit your right to contact an external agency or licensing board.

For complaints or grievances, you may contact Opsam Health Compliance at **(209) 683-5057**, by email at **compliance@opsam.org**, or by writing to the Compliance Department, Opsam Health, 637 3rd Avenue, Suite E1, Chula Vista, CA, 91910.

Notice To Clients
The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors. You may contact the Board online at www.bbs.ca.gov, or by calling (916) 574-7830.

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Clinician notice information may be completed below for the assigned clinician(s), or Opsam Health may provide this information in a separate written Notice to Clients and document delivery in the patient record.

☐ Separate written Notice to Clients provided and documented in the patient record.

Full name as filed with BBS	License/registration type	License/registration number	Expiration date

10. Patient Acknowledgement and Consent

By signing below, I acknowledge that I have read this Informed Consent for Behavioral Health Services, or had it explained to me, and that I had the opportunity to ask questions. I understand and agree to the terms related to my behavioral health therapy services and consent to receive behavioral health therapy services from Opsam Health. I understand that I may ask questions or withdraw consent for therapy at any time, and that my therapist may discuss potential risks, alternatives, referrals, or discharge planning if therapy is refused or discontinued.

Printed name of patient: _____

Date of birth: _____

Date signed: _____

Phone: _____

Signature of patient: _____

If signed by someone other than the patient:

☐ Parent or legal guardian
☐ Conservator
☐ Health care agent or personal representative
☐ Other: _____

Description of legal authority to sign: _____

Documentation of authority reviewed, if applicable: _____

Signature of legal representative, if applicable: _____

Date signed: _____

Relationship to patient: _____

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PATIENT CODE OF CONDUCT AND SAFE CARE AGREEMENT

Patient Full Name: _____ **Date:** _____

Date of Birth: _____

This Patient Code of Conduct and Safe Care Agreement (Agreement) applies to the patient and, when applicable, family members, caregivers, personal representatives, and visitors who come with the patient or communicate with Opsam Health on the patient's behalf.

By signing this Agreement below, I acknowledge the code of conduct expectations were provided to me and that I understand them. It does not waive patient rights and does not limit the right to emergency care, the right to file a complaint or grievance, the right to request medical records, or any civil rights protections.

1. Mutual Respect and Nondiscrimination

- Opsam Health will provide services without discrimination and will apply this policy consistently and in a nondiscriminatory manner.
- Patients may request language assistance, auxiliary aids, accessible formats, or reasonable modifications for a disability at no cost.
- If conduct may be related to a medical condition, disability, trauma, limited English proficiency, cognitive impairment, mental health condition, or substance-use concern, Opsam Health will consider reasonable, safe, and clinically appropriate steps such as de-escalation, interpreter services, auxiliary aids, modified communication, support-person involvement, or rescheduling before restricting non-emergency care.
- Opsam Health may take immediate safety steps when there is a credible threat, violence, weapon, stalking, harassment, property damage, or other conduct that creates an immediate risk to staff, patients, visitors, or the patient.

2. Patient, Family, Caregiver, and Visitor Expectations

I agree that I and anyone who accompanies me or contacts Opsam Health on my behalf will follow these expectations:

- Use respectful language and behavior with staff, providers, patients, and visitors.
- Do not make threats, intimidate, harass, stalk, shove, hit, throw objects, damage property, block exits, or engage in aggressive conduct.
- Do not use slurs, abusive comments, or derogatory or discriminatory language or conduct based on a person's race, color, ancestry, national origin, citizenship, immigration status, primary language, religion, sex, pregnancy, gender identity or expression, sexual orientation, age, disability, medical condition, genetic information, marital status, source of payment, or any other protected characteristic.
- Do not bring weapons or dangerous items onto Opsam Health premises, except for authorized law-enforcement personnel or as otherwise required by law.
- Do not use alcohol, cigarette, cannabis, illegal drugs, or misuse prescription medication on Opsam Health grounds. This does not prevent taking medications as prescribed or authorized.
- Do not come to the clinic in a condition that prevents safe care or creates a safety risk. If this occurs, Opsam Health may reschedule non-urgent care and help identify safer care options.

- Respect privacy. Do not take photos, videos, or audio recordings of staff, patients, visitors, medical records, computer screens, or clinic areas without permission. Do not enter restricted areas.
- Do not steal, falsify information, misuse another person's identity, tamper with clinic equipment, or engage in illegal activity.
- Follow reasonable clinic safety instructions, appointment procedures, visitor limits, infection-control requirements, and telehealth/portal communication rules.
- Supervise children and visitors who come with me, unless another arrangement has been made with staff.

3. What May Happen if Expectations Are Not Followed

Opsam Health will choose a response based on the seriousness of the conduct, patient safety, staff safety, clinical urgency, prior incidents, and applicable law. Possible responses include:

- A reminder, verbal redirection, or written warning.
- A request to stop the conduct, move to another area, use a different communication method, or limit communication to one designated contact or channel.
- Rescheduling or converting a non-urgent visit to telehealth or another safe setting when clinically appropriate.
- Asking the patient or visitor to leave the clinic for the day if it is clinically safe to do so.
- A behavior plan or meeting with clinic leadership or the care team.
- Security involvement, law enforcement, or emergency response if there is violence, a credible threat, a weapon, stalking, harassment, property damage, or other immediate safety risk.
- Review for possible termination of the patient-provider relationship when the conduct is repeated, severe, unsafe, or the therapeutic relationship can no longer continue safely.

Important limits on termination of care: Opsam Health will not terminate or restrict care solely because of a protected characteristic, disability, request for language assistance or reasonable modification, filing a grievance or complaint, exercise of patient rights, or inability to pay where termination is prohibited by law or payer rules. Opsam Health will review safety, clinical, civil-rights, payer, and continuity-of-care considerations before terminating non-emergency care.

4. If Opsam Health Terminates the Patient-Provider Relationship

If Opsam Health decides to terminate the relationship, Opsam Health will provide written notice unless immediate safety circumstances require a different lawful response. The notice will generally include:

- The effective date of termination, generally at least 30 days from the date of the notice unless a shorter period is legally permitted because of immediate safety risks or other circumstances.
- How the patient may obtain urgent, non-emergency care within Opsam Health's scope during the notice period, when clinically appropriate and safe.
- Instructions to call 911 or go to the nearest emergency room for emergencies.
- Reasonable transition information, which may include referral resources, health-plan/member-services contact information, medication/refill bridge information when clinically appropriate, and instructions for transferring medical records.
- How to contact Opsam Health about medical records, the grievance process, and any civil rights or accessibility concern.

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5. Patient Acknowledgements

I have read and/or had explained to me, the conduct expectations listed above and I have been offered the opportunity to ask questions related to the information in this Agreement. I understand that unsafe, disruptive and/or repeated inappropriate conduct may lead to warnings, being asked to leave for the day, safety restrictions, or termination of the patient-provider relationship after appropriate review and notice. I understand that this Agreement does not waive my rights, including my rights to emergency care, non-discrimination, privacy, medical-record access, language assistance, disability access and filing a complaint or grievance. I received or was offered Opsam Health's Patient Rights and Responsibilities Notice and grievance information

Signature: _____

Date: _____

Print name: _____

Relationship/Authority: _____

Staff Use Only - Patient Refused to Sign

Staff Name _____

Signature _____ Date _____

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FAMILY SIZE AND INCOME (FSI) INFORMATION FORM

(Used to see if you qualify for help based on Federal Poverty Level – "FPL")

We use this form to see if you can get help from Opsam Health or government assistance programs to pay for your care. These programs look at:

1. How many people are in your family; and
2. How much money your family makes before taxes are taken out.

If you need help filling out this form, please ask us.

1. Patient Information

Full Name: _____ Date of Birth: _____

2. If You Do Not Want to Answer

☐ I do **not** want to give my family and income information.

*If you check this box, you may **skip numbers 3-4** and **go to number 5** for your signature.*

3. Family Size - All people living in my household, including my spouse/domestic partner, & any individuals related to me by birth, marriage, or adoption.

Check all that apply & write numbers where asked.

☐ Myself (the patient)

☐ Husband / Wife / Spouse / Registered Domestic Partner

☐ Children (How many? _____)

☐ Other dependents who live with me related by birth / marriage (How many? _____)

TOTAL NUMBER (Please count all checked above) _____

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4. Family Income (Money Before Taxes are Taken Out) - Write the income before taxes ("gross income") for each person who helps pay the household bills. This includes money from jobs, benefits, and other income that is taxed.

My income (before taxes):	$ _____	☐ every 2 wks ☐ every month
Spouse/Registered Domestic Partner Income (before taxes):	$ _____	☐ every 2 wks ☐ every month
Other family member income (before taxes)	$ _____	☐ every 2 wks ☐ every month
Other family member income (before taxes)	$ _____	☐ every 2 wks ☐ every month
Other family member income (before taxes)	$ _____	☐ every 2 wks ☐ every month
TOTAL INCOME *(Please add all above)*	$ _____	☐ every 2 wks ☐ every month

5. Please Read and Sign

- *I promise that the information I gave on this form is true.*
- *I allow Opsam Health to use this information to see if I can get help from income-based programs.*
- *I will inform Opsam Health staff any time my income changes*.

Patient/Representative Signature: _____

Date: _____

Print name: _____

Relationship/Authority: _____

STAFF USE ONLY – PATIENT REFUSED TO FILL OUT & SIGN FORM

Date of refusal: ____ / ____ / ____ Staff full name: _____

Staff signature: _____

Comments (optional): _____

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SLIDING FEE DISCOUNT PROGRAM (SFDP) APPLICATION FORM

This program may help lower the cost of your care at Opsam Health. How much you pay is based on how many people live in your home and how much money your household makes. Please fill out this form if you want to apply for the discount.

1. Patient Information

Full Name: _____

Date of Birth: _____

2. Do You Want to Apply?

☐ YES, I want to apply for the discount program. *(Please fill out the rest of this form.)*

☐ NO, I do not want to apply. *(**SKIP** numbers 3 – 4 and **GO TO** number 5. Do **NOT** scan the QR code below and do **NOT** upload any documents.)*

3. Insurance Status

☐ I have insurance. ☐ I do **not** have insurance.

4. Proof of Income *(Recent pay stub, latest tax return, W2 or 1099 form, government benefits award letter, letter from employer)*

Are you able to provide proof of your income today?

☐ YES. **(*Please provide it to the staff.)***

☐ NO, I have proof of income but do not have it with me today. I will provide within 10 business days.

(*Use the QR code to submit OR drop in any clinic location.)*

SCAN ME

☐ NO, I am not able to provide or obtain proof of income ***(If you select this, please answer below AND complete the Self-Declaration Form separately.)***

- ☐ My employer does not provide pay stubs or written verification.
- ☐ I am paid in cash.
- ☐ I am self-employed or do informal work.
- ☐ I cannot contact my employer/former employer.
- ☐ I am unemployed.

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5. Agreement – Please Read and Sign

- I promise the information I give is true and correct.
- I allow Opsam Health to use this information to see if I qualify for a Sliding Fee Discount.
- I am responsible for paying my bill until I give proof of income.
- I will bring or send my income documents within **10 business days**.
- If I do **not** turn in my documents on time, I will be charged the **full fee**.
- I will tell Opsam Health if my income or insurance changes.
- My discount may change based on the new information, and if I overpaid, a refund may be given.

Signature: _____

Date: _____

Patient/Representative Name: _____

Relationship/Authority: _____

STAFF USE ONLY – PATIENT REFUSED TO FILL OUT & SIGN FORM

Date of refusal: ____ / ____ / ____ Staff name (print): _____

Staff signature: _____

Comments (optional): _____

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NOTICE ABOUT THE OPEN PAYMENTS DATABASE

Opsam Health is sharing this notice with patients as required by California law.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at: https://openpaymentsdata.cms.gov

This database is for informational purposes only. It does not affect your care, your eligibility for services, or the cost of your care at Opsam Health.

Please ask our staff if you need help finding the website or understanding this notice.

ACKNOWLEDGMENT OF RECEIPT

By signing below, the patient, parent, or legal representative acknowledges receiving this notice.

Signature: _____

Date: _____

Patient/Representative Name: _____

Relationship/Authority: _____