Whitman-Walker Health

Mailing Address:
Whitman-Walker Health
1525 14th St. NW
Washington, DC 20005

Welcome to Whitman-Walker Health! We look forward to you joining our healthcare family.

Incorporated in 1978, Whitman-Walker Health is a nonprofit community health center focused on removing barriers to accessing care in the Washington, DC, metropolitan area. Whitman-Walker works to provide stigma-free healthcare and support services to the gay, lesbian, bisexual, transgender and non-binary communities of greater Washington, and people living with or affected by HIV. Through multiple locations in the district, Whitman-Walker serves 20,000 individuals with medical and dental care, mental health and addiction services, legal services, youth programming and more. We extend affirmation, dignity and respect to everyone we provide care to.

This packet includes the following:

- Patient Registration
- Consents and Acknowledgment
- Patient Acknowledgment of Financial Obligation
- Patient Rights and Responsibilities Statement
- Notice of Privacy Practices

You might be wondering why it's important for you to completely fill out your registration form. Here's why:

- The information you provide helps us learn about you and better serve you. This information includes your preferred name and gender pronouns.
- It also helps us comply with grants we apply for and provide services through. To keep receiving grant funding and serve you affordable care, we need for you to answer all questions on the form, including information about your annual income, family size, and housing.

This information will become a part of your health record. It is kept confidential. It is protected by law just like all of your health information.

Thank you for choosing Whitman-Walker Health for your healthcare needs and for taking time to complete these forms. We appreciate you!

Sincerely,

Sarah Henn, MD
Chief Health Officer

Patient Self-Attestation and Registration Form

Updated 2022-9-21

Last Name	**First Name**	**Middle Initial**
I go by (name)	**Pronouns**- choose all that apply ❑ **He** ❑ **She** ❑ **They** ❑ **Ze** ❑ **Another:**	
Date of Birth (mm/dd/yyyy)	**Social Security #**	

Address	City	State	Zip code
Is your housing? ❑ **Stable** ❑ **Unstable** ❑ **Temporary** ❑ **Homeless**	**DC Ward** ______ ❑ **Don't know** ❑ **Not a DC Resident**		
Email address this is used to create your Patient Portal. Please note your First Name and Preferred name will appear in the Patient Portal.			
Cell #	**Home #**		
Emergency Contact Name	**Phone #**	**Relationship to you**	
Whitman-Walker Health will send correspondence through the patient portal, text, email, and the US Mail. Statements are sent first by using text and email, and last to your mailing address. Please note your First Name and Preferred Name will appear on Statements mailed to your address and the patient portal.			

Do you have insurance? ❑ **No** ❑ **Yes**	*If you do not have insurance, you must meet with Public Benefits and Insurance Navigators. You may be eligible for insurance or our sliding fee schedule for your services. To determine your eligibility, you must provide income, family size, and residency documentation. Until we receive your documentation, you will be responsible for the full fee for your services.*		
Insurances we do not accept	*If we do not accept your insurance, we encourage you to select a provider who takes your insurance. Choosing to get your care with us will mean being charged the full fee of your care and seeking reimbursement from your insurer.*		
#1 Insurance Company Name	**Subscriber #** ❑ **Employer Paid** ❑ **Individual Paid**	**Group #**	**Contact #** on back of card
#2 Insurance Company Name	**Subscriber #** ❑ **Employer Paid** ❑ **Individual Paid**	**Group #**	**Contact #** on back of card
	Is the responsible party a Whitman-Walker patient? ❑ **Yes** ❑ **No**		

WWH recognizes a number of genders/sexes; we are continuously trying to improve our own systems and the systems with which we interact. Please be aware that the name and sex listed with your insurance and identification cards will be used on documents pertaining to insurance, billings, referrals, records, patient portal, and correspondence. We apologize for challenges this may cause. If you would like assistance or information about updating your identity documents, please contact WWH Legal Services at 202-939-7630.

What sex/gender marker is on file with your insurance company? ❑ **M** ❑ **F**

❑ **For HIV+ patients:** I understand that I may be eligible for savings on my healthcare if I incur a certain level of healthcare expenses. I understand that the income and family size information may be used to calculate eligibility for Ryan White. For more information, I will call the Public Benefits and Insurance line at 202.745-6151.

This information is for demographic purposes only and will not affect your care.

What is your annual income?

$____________________

❑ **No Income**

How many people (including you) does your income support? (Enter as least 1)

____

Are you a Veteran of the US Military (NOT Active Duty)?

❑ **Yes**

Racial Group(s) (check all that apply)

❑ **African American/Black** *(including Africa, Caribbean)*
❑ **American Indian or Alaska Native** *(including all Original Peoples of the Americas)*
❑ **Asian** (please specify)
- ❑ **Asian Indian**
- ❑ **Chinese**
- ❑ **Filipino**
- ❑ **Japanese**
- ❑ **Korean**
- ❑ **Vietnamese**
- ❑ **Other Asian**

❑ **Native Hawaiian/Pacific Islander** (please specify)
- ❑ **Native Hawaiian**
- ❑ **Samoan**
- ❑ **Guamanian or Chamorro**
- ❑ **Other Pacific Islander**

❑ **White**

Sexual Orientation

❑ **Lesbian or Gay**
❑ **Straight or Heterosexual**
❑ **Bisexual**
❑ **Do not know**
❑ **Choose not to disclose**
❑ **Something else:** ____________________

Ethnicity

❑ **Non-Hispanic/Non-Latino**
❑ **Hispanic/Latino(a)** (please specify)
- ❑ **Cuban**
- ❑ **Mexican, Mexican American, Chicano/a**
- ❑ **Puerto Rican**
- ❑ **Another Hispanic, Latino/a, Spanish Origin**

How do you describe your Gender?

❑ **Female/Woman**
❑ **Male/Man**
❑ **Trans woman or trans feminine**
❑ **Trans man or trans masculine**
❑ **Genderqueer/Non-binary/not exclusively male or female**
❑ **Choose not to disclose**
❑ **Another gender:** ____________________

Preferred Language (choose one)

❑ **English**
❑ **Spanish**
❑ **Amharic**
❑ **Other:** ____________________
Do you require an interpreter? ❑ **Yes** ❑ **No**

If you are Deaf or Hard of Hearing, do you request:

❑ **ASL Live Interpreter** ❑ **ASL Video Remote Interpreter**

Sex Assigned at Birth

❑ **Female**
❑ **Male**

Do you identify as Trans or of Transgender experience?

❑ **Yes**
❑ **No**

I attest the information on this form is correct to the best of my knowledge. I will update WWH if anything changes.

____________________ ____________________
Signature **Date**

WHITMAN-WALKER HEALTH

Consents and Acknowledgments

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information or need help completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

GENERAL CONSENT TO TREAT

I voluntarily agree to receive services from WWH, and authorize the providers of WWH to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that I should participate in the planning for my care and that I have a right to refuse interventions, treatment, care, services or medications at any time to the extent the law allows. I know that the care I will receive may include tests, injections, and other medications, etc., that are based on established medical criteria, but not free of risk. Finally, I know that WWH sometimes has students/residents being trained as doctors, nurses, therapists and other health care providers who might be helping to care for me. These individuals are under the supervision of licensed providers. I understand that WWH is committed to involving me in my care and that no one can be given care at WWH without agreeing to the care unless there is an emergency. If there is an emergency, I know that someone at WWH may help me without waiting for me to say okay. I understand that some services require me to sign another Informed Consent to Treatment so I may be asked to complete that later.

NOTICE OF PRIVACY PRACTICE

I have been given a copy of WWH's Notice of Privacy Practices and I understand that WWH is required by law to protect my personal health information. I have had the chance to ask questions about WWH's Notice of Privacy Practices and feel comfortable with the protections that it offers me. I understand that there are times when the law allows my personal health information to be shared with individuals or entities outside of WWH, including but not limited to for treatment, payment and operations purposes, when required by law, and in connection with the mandatory reporting of certain diseases.

INTEGRATED MODEL OF CARE

WWH offers a wide variety of services to its clients. I understand that in order for me to get the best service for my needs, programs within WWH may share information concerning my health to ensure the quality and continuity of my care across service areas. For example, WWH may share my demographic information, medical and other service referrals, and other non-clinical information with WWH Legal Services to allow for legal referrals and for scheduling purposes. The details of my health records will only be shared with WWH lawyers if I agree for them to take my legal case.

HEALTH INFORMATION EXCHANGE AND PDMP

I understand that WWH participates in the Chesapeake Regional Information System for Our Patients (CRISP) Health Information Exchange (HIE) and the Capital Partners in Care (CPC) HIE. These HIEs provide a way of sharing my health information among participating doctors' offices, hospitals, labs, radiology centers, and other providers through secure, electronic means. I have been informed that my health information, including information relating to the mental health services I receive at WWH, will be shared with the HIEs in order to better coordinate my care and assist providers and public health officials in making more informed decisions. I have been advised by WWH that I have the right to "opt-out" of the HIEs at any time. I understand that I can request a copy of WWH's "opt-out" form and direct WWH to disable access to my health information, except to the extent that disclosure of such information is permitted or mandated by law.

I also acknowledge that it may be necessary for my Whitman-Walker Health provider to obtain information about my medications through the Prescription Drug Monitoring Program (PDMP) as required by state law.

PATIENT RIGHTS AND RESPONSIBILITIES

I have been given a copy of the WWH Rights and Responsibilities document and understand that both WWH and I are responsible for adhering to the Rights and Responsibilities. I understand that I have a right to file a complaint or grievance with WWH, as described on the WWH website and in the Patient Feedback notice posted on bulletin boards at the health center. I also understand that WWH has a Patient Handbook that contains information about being a patient at WWH including services offered, hours of operation and contact information.

WHITMAN-WALKER HEALTH

Consents and Acknowledgments (CONTINUED)

RELEASE OF INFORMATION FOR BILLING AND CONSENT TO REIMBURSE

I know that WWH needs to send parts of my personal health information to organizations that help pay for my care, such as my insurance company or an organization that grants money to WWH. I allow WWH to release the relevant parts of my records so that my care can be paid for. If I do not feel comfortable with this, then I understand that I can request a higher level of privacy protection than is afforded to me under the Health Insurance Portability and Accountability Act (HIPAA).

CONSENT TO COMMUNICATIONS VIA E-COMMUNICATIONS

The U. S. Department of Health and Human Services permits patients to request electronic communications with their providers. I acknowledge that the most secure means of communicating with WWH is by use of the patient portal. Any other method of communicating electronically presents a greater risk of breach of privacy because the communications may be intercepted by third parties or transmitted to unintended parties. WWH will make an effort to limit the information it includes in e-communications with me. I understand, however, that information about my medical care (including appointments, billing information, prescriptions and test results) may be sent to me electronically. By signing below, I am choosing and consenting freely to electronic communications. If I wish to discontinue e-communications with WWH, I can submit an E-communications Opt-Out Form available from Client Services or on the WWH website.

ACKNOWLEDGMENT OF DUTY TO REIMBURSE WWH FOR HEALTH CARE SERVICES

I understand that WWH offers a Sliding Fee Scale of discounted or free health care items and services to individuals who are deemed unable to pay based on their level of income. In order to be eligible for WWH's Sliding Fee Scale of discounted or free services, I will need to provide WWH's Public Benefits and Insurance Navigation team with documents establishing that I meet income eligibility requirements. If I do not provide the required documents to WWH, I am responsible for paying my fees for medical, behavioral health, or dental services received at WWH in full at the time of service. I also understand that if I am an insured patient with insurance WWH does not accept, or an insured patient with a copay obligation who fails to pay fees or copays due at the time of service, I will not be scheduled for future appointments until such time as my outstanding fees or copays are paid.

By signing my name below, I am acknowledging that I have read, and fully understand, each of the separate paragraphs set forth above.

Signature:	**Date:**
Printed Name: (If other than patient, print relationship)	**Date of Birth:**

CONSENT TO RECEIVE MEDICAL, DENTAL AND BEHAVIORAL HEALTH SERVICES VIA TELEHEALTH

This form gives you facts about, and risks of, telehealth services.

By signing this form, or verbally agreeing to its terms, you consent to receive telehealth services and treatment by a Whitman-Walker Health medical, dental or behavioral health provider, and you acknowledge your understanding and agreement to the following:

- You will be participating in a medical, dental or behavioral health telehealth visit at a location different from where your Whitman-Walker Health provider is located, which may limit the ability of your provider to provide medical care. For example, your provider will not be able to conduct an in-person physical examination and cannot provide emergency medical services during a telehealth visit.

- It is the role of your provider to determine whether or not the condition you are being diagnosed with or treated for is appropriate for a telehealth visit.

- You or your provider may require an in-person examination before or after diagnosing or prescribing a treatment plan.

- If you are experiencing a medical or mental health emergency, you understand you will be asked to immediately call 911 or go to the nearest emergency room.

- This telehealth visit and future telehealth visits will be conducted with the use of real-time interactive two-way audio, video or other electronic communications. Whitman-Walker Health has taken steps to protect the security of information disclosed during the session, but Internet security and privacy are not guaranteed. You understand that (1) security protocols could fail, potentially causing a breach of your protected health information, (2) information you transmit through telehealth technology may be insufficient to allow for appropriate medical decision-making by your provider (for example, poor image resolution); or (3) failures of equipment (for example, servers, devices) or infrastructure (for example, communications lines, power supply) may cause delays in medical evaluation and treatment, or loss of information, and you agree to hold Whitman-Walker Health harmless for any loss of protected health information that occurs due to technological failure.

- Whitman-Walker Health will need to obtain an accurate medical and mental health history, condition(s) and description of current or previous medical or mental health care from you during telehealth sessions to best support diagnosis, therapy, follow-up and/or education.

- Your provider may have other medical staff participate in your telehealth visit and you agree to medical staff participation. You have the right, at any time, to request the medical staff to leave the telehealth visit.

- If you allow another person to participate in your telehealth visit (e.g., family, caregiver), you consent to their participation.
- Whitman-Walker Health may share your identifiable information from your telehealth visits with third parties, except as prohibited by law. Whitman-Walker Health may separately request your consent to share identifiable information from your telehealth visits with third parties, as necessary.
- There are potential risks to telehealth, such as technological interruptions, unauthorized access, and technical difficulties. Your provider will obtain or confirm your contact information in order to reach you in the event of a technical issue.
- You or your provider can stop any telehealth visit if either of you feel that the videoconferencing connections are not adequate for the situation.
- Having a telehealth visit is your choice. Even if you have agreed to the session, you can change your mind about participating in this or future telehealth sessions. You have the right to withdraw your consent.

BY SIGNING YOUR NAME BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ (OR HAVE HAD READ TO YOU), AND UNDERSTAND EACH OF THE SEPARATE PARAGRAPHS ABOVE, YOU HAVE HAD A CHANCE TO ASK WHITMAN-WALKER HEALTH STAFF ANY QUESTIONS YOU MAY HAVE, AND YOU CONSENT TO THE TELEHEALTH SERVICES AND TREATMENT PROVIDED TO YOU BY WHITMAN-WALKER HEALTH.

This Consent lasts for as long as telehealth services continue, unless you exercise your right to withdraw your consent at any time.

If you are not able to place a wet signature or electronic signature on this Consent and return it to Whitman-Walker Health, you will verbally inform Whitman-Walker Health that you have reviewed this form and provide your verbal consent. Whitman-Walker Health will document your consent to telehealth services in your electronic medical record.

______ **COURT ORDER PROVIDED WHEN APPLICABLE (copy attached)**
Initials of medical provider to verify that a copy is attached

Printed Name of Patient:	**Date of Birth:**
Signature: *(If applicable)*	**Date:**
Patient Location for telehealth visits (list state):	
Printed Name of Parent/Legal Guardian (if applicable):	
Relationship to Patient:	
Signature:	**Date:**

WHITMAN-WALKER HEALTH

Patient Acknowledgment of Financial Obligation

PREAMBLE

Whitman-Walker Health ("WWH") is a Federally Qualified Health Center ("FQHC" or "Health Center") that is subject to Section 330 of the Public Health Service Act. Section 330 specifies that Health Centers must assure that no patient will be denied services due to their inability to pay for such services. It also requires Health Centers to adopt written policies and procedures to maximize collections and reimbursement for their costs in providing health services.

I UNDERSTAND THAT I AM RESPONSIBLE FOR:

- Contributing to the cost of my care and treatment as my health insurance coverage requires and based on my ability to pay;
- Providing WWH with the information it needs to receive reimbursement for the treatment or services it provides to me;
- Requesting consideration for discounted fees under WWH's Sliding Fee Scale based on my level of income, and providing documentation to support eligibility for discounted fees that may be requested by WWH's Public Benefits and Insurance Navigation team;
- Assisting the Public Benefits and Insurance Navigators with any application for insurance or public benefits that I may be entitled to;
- Paying my co-payment (if applicable) when I check-in for my appointment and paying my deductible or any other fees that may be owed at the conclusion of the medical visit;
- Paying my fees for medical, behavioral health, or dental services received at WWH in full at the time of service, either upon check-in or at check-out as requested by WWH if I have been deemed a self-pay patient based on the fact that I have insurance coverage that WWH does not accept but have elected to remain in care at WWH.

I understand that if I am an insured self-pay patient or an insured patient with a copay obligation who fails to pay fees or copays due at the time of service, I will not be scheduled for future appointments until such time as my outstanding fees or copays are paid. If I fail to pay my outstanding fees or copays in 30 days, WWH presumes that you are transitioning your care to another provider. If you have a health care issue requiring immediate care during the next 30 days, you may contact WWH and your provider will determine whether you should be seen. To prevent you from running out of medications, a thirty (30) day renewal will be made available if needed.

Signature:	**Date:**
Printed Name: (If other than patient, print relationship)	**Date of Birth:**

Whitman-Walker Health
we see you.

Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed by Whitman-Walker Health (WWH) and how you can get access to this information. Please review it carefully.

I. OUR COMMITMENT TO YOUR PRIVACY

WWH is committed to protecting the privacy of health information that we create or obtain about you. This Notice tells you about the ways in which we may use and disclose your health information and describes both your rights as well as our obligations regarding that use and disclosure.

We are required by law to make sure that your health information is protected, to give you this Notice describing our legal duties to protect your privacy, and to follow the terms of the Notice that is currently in effect. We reserve the right to change the terms of this Notice and to make a new Notice effective for all health information that we maintain.

II. WHO THIS NOTICE APPLIES TO

This Notice applies to WWH, consisting of its facilities, departments, clinics, and any other entities of WWH that are considered Covered Entities as defined under HIPAA; all WWH physicians, dentists, other licensed professionals, employees, volunteers, and trainees. This Notice, however, does not apply to any WWH providers regarding their private offices.

III. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

Right to Inspect and Copy your Health Information.

With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing records, or any of the other records that are used by us to make decisions about your care. You may request that we send a copy of your health information to a third party.

To inspect and/or receive a copy of your medical records, we require that you submit your request in writing to your WWH health care provider or to the WWH Medical Records

Department. If you request a copy of your medical records, we may charge you a reasonable cost-based fee for the cost of providing you with copies. In some cases, medical records may be provided free of charge. Under certain circumstances, however, we may deny your request to inspect or copy your records. If we deny your request, we will explain the reasons to you and in most cases, you may have the denial reviewed.

Generally, you can readily access without delay much of your electronic health information using the WWH patient portal. Information about the patient portal is available at WWW.Whitman-Walker.org/patient-login.

Right to Request an Amendment

If you think that the health information we have about you is incorrect or incomplete, you may ask us to correct the information, for as long as the information is kept by, or for, WWH in your medical and billing records. To request an amendment, submit your request in writing to the WWH Privacy Officer and provide the reason for the request. If we agree to your request, we will amend your record(s) and notify you of such. In certain circumstances, we cannot remove what was in the record(s), however, we may add supplemental information to clarify. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Request confidential communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail. If you want us to communicate with you in a certain way, you will need to give us specific details about how you want to be contacted including a valid, alternative address. We will not ask you the reason for the request, and we will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations that you have requested, we may contact you using the information that we have.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or our operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. If we agree to your request, we will comply with your request unless the information is needed to provide you with emergency treatment or if we are required by law to disclose it.

However, we are not required to agree to your request, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations of the health

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plan, and the information pertains solely to a health care item or service for which we have been paid "out of pocket" in full.

To request a restriction, you must make your request in writing to the WWH Privacy Officer (address and number provided below) and tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply. We are allowed to end the restriction if we tell you. If we end the restriction, it will only affect the health information that was created or received after we notify you.

Right to an Accounting of Disclosures

You can ask for a list (accounting) of the times we have disclosed your health information.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

To request an accounting of disclosures, submit your request in writing to the WWH Privacy Officer (address and number provided below). Please provide the time period for which you want to receive the accounting, which may not be longer than six years and which may not date back more than six years from the date of your request.

Right to a paper copy of this Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. Copies of this Notice are available at WWH facilities, from the WWH Privacy Officer (address and number provided below) and on the WWH website at Whitman-walker.org/hipaa.

Right to choose someone to act for you

If you have given someone health care (medical) power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

Our Legal Services Department can assist you with the preparation of a health care power of attorney document if you do not have one, which provides authority for another person to act on your behalf.

IV. OUR USE AND DISCLOSURE OF YOUR INFORMATION

The following sections describe different ways that we may use and disclose your health information. Not every use or disclosure will be listed. However,all of the ways that we are permitted to use or disclose information will fall within one of these categories.

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To treat you

We may use or disclose health information about you to provide you with medical treatment or health care services. We may disclose information about you to health care providers involved in your care. For example, a doctor may need to review your medical history before treating you. We may share health information about you with other health care providers, agencies, or facilities not affiliated with WWH in order to provide or coordinate the difference things you need, such as prescriptions, lab work, and x-rays. We may contact you to provide appointment reminders, patient registration information, information about treatment alternatives or other health-related benefits and services that may be of interest to you, or to follow-up on your care.

To run our organization

We may use and disclose health information about you for our health care operations, which are various activities necessary to run WWH's business, provide quality health care services, and contact you when necessary. For example, we may share your health information to coordinate your care, evaluate our providers' performance in caring for you, and for quality improvement activities. We may disclose your health information to medical, nursing, or other students and trainees for review and learning purposes.

In order to bill for your services

We may use and disclose health information about you for billing and payment activities. For example, we may use and disclose information so that WWH can obtain payment from you, an insurance company, or another third party. We may also tell your insurance company about a treatment that you need to obtain prior approval or check if your insurance will pay for the treatment.

Health Information Exchange

Health information exchanges (HIEs) provide a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other providers through secure, electronic means. WWH is participating in the Chesapeake Regional Information System for Our Patients (CRISP) Health Information Exchange and the Capital Partners in Care (CPC) Health Information Exchange. As permitted by DC Mental Health Information Amendment Act of 2018, your mental health information, along with your physical health information, will be shared with the CPC and CRISP HIEs to provide faster access, better coordination of care, and improved knowledge for providers. If you do not want your physical and mental health information to be shared among your providers, you have the right to opt-out of the HIEs at any time by completing an Opt-Out Form available at the WWH front desk. Note, however, that it is not possible to share some, but not all, of your health and mental health information. If you opt-out of one or both HIEs, none of your health information, neither physical nor mental, will be shared with that HIE for purposes of coordinating your care and treatment. It may also be necessary for your WWH provider to obtain information about your medications through the Prescription Drug Monitoring Program (PDMP) as required by state law.

Business Associates

We can share information to third parties referred to as "business associates" that provide services on our behalf, including such things as software and other IT support, patient navigation, and legal and other professional services, We require our business associates to sign an agreement requiring them to protect your information and to use it only for the purposes for which we have contracted.

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Fundraising
Although HIPAA permits us to contact you to raise funds and provide information about Whitman-Walker-sponsored activities, we generally do not do so. If you would like to learn more about how you can support WWH, please contact Charles Hastings at CHastings@Whitman-Walker.org. Likewise, if you want to "opt-out" of fundraising communications from us, contact Charles Hastings to do so.

Individuals involved in care or payment for your care
Unless you tell us not to, we may release health information to anyone involved in your medical care, such as a friend, family member, or any individual you identify. We may also give your information to someone who helps pay for your care. If you are unable to tell us your preference, for example, if you are not present or are unconscious, we may share your health information that is directly relevant to the person's involvement with your care if we believe it is in your best interest. Additionally, we may disclose information about you to your legal representative.

Research
We may use and disclose your information for certain research purposes in compliance with the requirements of applicable law. All research, however, is subject to a special approval process, which establishes protocols to ensure that your information will continue to be protected. When required, we will obtain a written authorization from you prior to using your information for research.

When required by law
We will disclose health information about you when required to do so by federal, District of Columbia, and/or state law. This includes, but is not limited to, disclosures to mandated patient registries, including reporting adverse events with medical devices, food, or prescription drugs to the Food and Drug Administration.

Oversight Activities
We may disclose health information to health oversight agencies for activities authorized by law. These oversight activities may include licensure activities and other activities by governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Public Health Activities
We may disclose your health information for public health activities including disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect or domestic violence; or notify a person who may have been exposed to a disease or condition.

Lawsuits and other legal actions
We may disclose health information about you to courts, attorneys, court employees and others when we get a court order, subpoena, discovery request, warrant, summons, or other lawful instructions. We may also disclose information about you to WWH attorneys and/or attorneys working on WWH's behalf to defend ourselves against a lawsuit or other legal action.

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Law enforcement purposes/ law enforcement official.
We may disclose your health information to the police or other law enforcement officials to report or prevent a crime or as otherwise required or permitted by law.

Use and disclosure in special situations
We may use and disclose your health information in the following special situations:

- **Serious Threats to Health or Safety**

We may use and disclose health information about you to help prevent a serious and imminent threat to your health and safety or the health and safety of the public or another person.

- **Respond to organ and tissue donation requests**

We can share health information about you with to organizations that handle organ procurement, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

- **Coroner, medical examiner or funeral director**

We can share health information about a deceased patient with a coroner, medical examiner, or funeral director as necessary to carry on their duties.

- **Disaster relief efforts**

We may disclose health information about you to an organization assisting in a disaster-relief effort so that your family can be notified about your condition, status, and location.

- **Workers' compensation claims**. We may disclose health information about you for workers' compensation claims or similar programs as authorized or required by law.

- **Presidential protective services**. We may disclose health information about you to authorized federal officials so they may conduct special investigations or provide protection to the President of the United States, other authorized persons, or foreign heads of state as authorized by law.
- **Military**. If you are a member of the armed forces, domestic (United States) or foreign, we may release health information about you to the military authorities as authorized or required by law.

- **National security and intelligence activities**. We may disclose health information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities as required by law.

- **Inmates**

  If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release health information about you to the correctional institution or law enforcement officials as authorized or required by law.

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V. USES/DISCLOSURES OF HEALTH INFORMATION REQUIRING AUTHORIZATION

Marketing purposes. We generally do not share your information for marketing purposes unless you give us permission to do so.

Sale of your information. We must obtain your written permission to sell or receive anything of value in exchange for your health information, with certain limited exceptions.

Psychotherapy notes. We must obtain your written permission to disclose psychotherapy notes, except in certain circumstances. For example, written permission is not required for use of these notes by their author with respect to your treatment or the use of disclosure by us in the training of mental health practitioners, or to defend WWH in a legal action brought by you.

Other Uses and Disclosures. Other uses and disclosures of your health information not covered by the categories included in this Notice or applicable laws, rules, or regulations will be made only with your written permission or authorization. If you provide us with such written permission, then you may revoke it at any time. We are not able to take back any uses or disclosures that we already made with your authorization. We are required to retain your health information regarding the care and treatment that we provided you.

VI. OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

We will let you know in writing if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this Notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We will not share with third parties, without your written authorization, unless permitted to do so by law: (i) records relating to your participation in a WWH substance use disorder ("SUD") program (including the Whitman-Walker Addiction Services Co-occurring Program (WWAS Co-OP), the Substance Use Management for Harm Reduction, Understanding Your Use Group, and our other 42 CFR Part 2 programs) or (ii) your mental health records.

VII. QUESTIONS/COMPLAINTS

If you have questions or believe that your privacy rights have been violated, you may file a complaint with WWH or with the Secretary of the Department of Health and Human Services. You

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will not be retaliated against for filing a complaint.

Contact Information/How to File a Complaint

Write to Whitman-Walker Health, Whitman-Walker at Liz, 1377 R Street N.W., Suite 200, Washington, DC 20009, Attention: Compliance/Privacy Office, or call (202) 745-7000.

Write to the U.S. Department of Health and Human Services Office for Civil Rights 200 Independence Avenue, SW, Washington, DC 20201, or call 1.877. 696.6775, or visit www.hhs.gov/ocr/privacy/hipaa/complaints.

VIII. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and WWH privacy practices. We further reserve the right to make the revised or changed Notice effective for information that we already have about you, as well as any information that we receive in the future.

We will post a copy of the current Notice on the WWH website at Whitman-Walker.org/hipaa.

The Notice will specify the effective date of the Notice. Each time you visit our website you will see a link to the current Notice in effect.

The original effective date of this Notice is April 14, 2003 and the Notice was most recently updated on March 28, 2023 and replaces all earlier versions.

Acknowledgement of receipt of this Notice of Privacy Practices is indicated by your signature on our *Consents and Acknowledgement Form* that is scanned into your electronic medical record.

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WHITMAN-WALKER HEALTH
we see you.

Questions about Name, Gender, and Sexual Orientation: An Informational Guide for Patients

Thank you for taking the time to complete these questions.

If you have additional questions, please speak with the front desk and they will be happy to help.

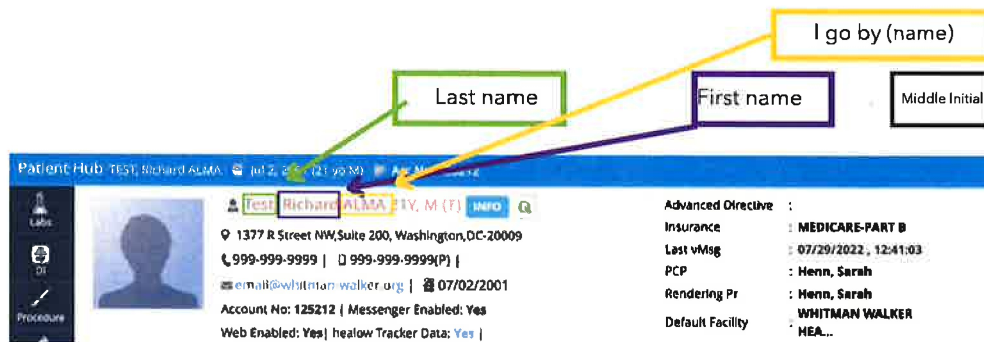
We are asking you about your sexual orientation and gender identity in order to provide more patient centered care. Read inside to learn what the questions mean, and how the information can be used to improve health care for everyone.

Why ask about my Name and what I go by?

We want to make sure we ask you and call you by your name. We ask for the name you go by, if different from your legal name. This will help correctly display it in the medical record.

We ask for your legal name because we need to record what is on your insurance. This will help avoid billing errors or rejections.

- If your name is different from your legal name, the medical record will show BOTH. We show your name in ALL CAPS, so it is highlighted as different from your legal name. They will show side by side in the medical record. In this example, Richard is the name on their insurance card. ALMA is the patient's name. Test is their last name. The image below shows how this patient's name appears in the medical record.



Why ask to select pronouns?

Pronouns are the words used to refer to someone without using that person's name. Using incorrect pronouns can be very hurtful, even by accident. It is important to ask you for your pronouns and for us to use those pronouns.

Pronouns- choose all that apply
☐ He ☐ She ☐ They ☐ Ze ☐ Another:

ANY QUESTIONS?
We are here to help.

Why ask about my sexual orientation?

Learning about the sexual orientation of our patients helps us better serve you. It allows us to offer culturally responsive, fair and equitable care that focuses on your specific needs. This information is shared with our funders, which helps support LGBTQ+ programs.

Sexual orientation is how people describe their emotional and physical attraction to others. For example: Gay or Lesbian, Straight/Heterosexual, Bisexual, Queer, Asexual, etc.

Sexual Orientation

- ❑ **Lesbian or Gay**
- ❑ **Straight or Heterosexual**
- ❑ **Bisexual**
- ❑ **Do not know**
- ❑ **Choose not to disclose**
- ❑ **Something else: ______________________**

Why ask about my gender identity?

Learning about the gender identity of our patients helps us better serve you. It allows us to offer culturally responsive, fair and equitable care that focuses on your specific needs. This information is also shared with our funders, which helps support LGBTQ+ programs.

Gender identity is a person's inner sense of being. For example: a girl/woman/female, a boy/man/male, something else, or having no gender.

How do you describe your Gender?

- ❑ **Female/Woman**
- ❑ **Male/Man**
- ❑ **Trans woman or trans feminine**
- ❑ **Trans man or trans masculine**
- ❑ **Genderqueer/Non-binary/not exclusively male or female**
- ❑ **Choose not to disclose**
- ❑ **Another gender: ______________________**

Why ask about my Trans identity or Transgender experience?

Learning about the Trans identity or Transgender experience of our patients helps us better serve you. It allows us to offer culturally responsive and equitable care that focuses on your specific needs. This information is shared with our funders, which helps support LGBTQ+ programs.

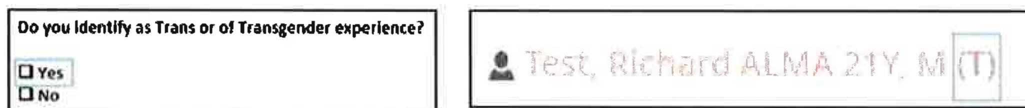
Transgender describes people whose gender identity and sex assigned at birth do not correspond based on traditional expectations.

Non-binary is a term under the transgender umbrella. It describes people whose gender identity falls outside the traditional binary of man/woman.

Cisgender describes people whose gender identity and sex assigned at birth do correspond. This is another way to say, "not transgender."

If you answer "Yes" to this optional question, a "T" is displayed next to your name in the medical record.

Please see below for how it will appear in our system.



Why ask about my sex assigned at birth?

Sex Assigned at Birth (SAAB) is commonly used, along with other information, to suggest preventative medical screenings. We believe a more thoughtful and affirming approach is to ask about surgical history. That approach is also called an "organ inventory", though this is not yet common practice. An inventory recognizes that all bodies have different histories and parts. The inventory helps with decision making between you and your provider that honors your gender identity, sex assigned at birth, and anatomy.

*If you have recently updated your gender marker with your insurance, let us know. We would be happy to update our records: transhealth@whitman-walker.org

Sex assigned at birth is also known as birth sex. It refers to the label given to infants based on their genitals. Most people are labeled either male or female. This label goes on one's birth certificate. We say sex assigned at birth instead of "biological sex." Saying sex assigned at birth acknowledges that someone else (often a doctor) is deciding that label for someone else. Having only two options (male or female) does not capture the full spectrum of sex. That assignment may not support what's going on with a person's body, how they feel, or how they identify.

Intersex refers to people who are born with any of many sex traits. These traits do not fit typical binary notions of male or female.

Sex Assigned at Birth

☐ **Female**
☐ **Male**

What are my options for answering these questions?

We understand it can feel scary answering these questions. Folks have been judged by sharing this information before. We are asking about your identities so that your experiences are seen and counted. Knowing more about you helps us build services and a health center that celebrates you.

You can select "Choose not to disclose" for questions you do not wish to answer.
It unfortunately isn't possible to list every sexual orientation or gender identity. If yours isn't included in the lists provided, please write in a response using the space "______".

How do you describe your Gender?

- ❑ Female/Woman
- ❑ Male/Man
- ❑ Trans woman or trans feminine
- ❑ Trans man or trans masculine
- ❑ Genderqueer/Non-binary/not exclusively male or female
- ❑ Choose not to disclose
- ❑ Another gender: ____________________

Sexual Orientation

- ❑ Lesbian or Gay
- ❑ Straight or Heterosexual
- ❑ Bisexual
- ❑ Do not know
- ❑ Choose not to disclose
- ❑ Something else: ____________________

Why ask about my "sex/gender marker on file with insurance"?

We ask for your "sex/gender marker on file with insurance company" to avoid billing errors or rejections. We need this documentation to be up to date.

What does this mean for how information (including name and "sex") appears in my medical record, Healow app, or Patient Portal?

As with most medical record systems, ours reflects an imperfect, two-option system.

Unfortunately, this does not capture the range of people's identities and experiences. When we document "sex" in our medical record, that information is used by insurance for payment decisions. Documentation for "sex" in our medical record needs to match what's on file with your insurance. This helps avoid billing rejections or errors.

WWH recognizes a number of genders/sexes; we are continuously trying to improve our own systems and the systems with which we interact. Please be aware that the name and sex listed with your insurance and identification cards will be used on documents pertaining to insurance, billings, referrals, records, patient portal, and correspondence. We apologize for challenges this may cause. If you would like assistance or information about updating your identity documents, please contact WWH Legal Services at 202-939-7630.
What sex/gender marker is on file with your insurance company? ❑ M ❑ F

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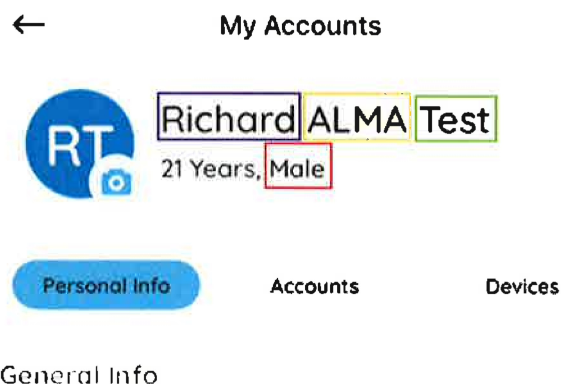
we see you.

Here are a few things to know:

- The medical record will display the name and gender on file with your insurance. If you've recently updated your name or gender marker, or if you have questions about how that's displayed in our system, please email us at transhealth@whitman-walker.org
- For example, the name displayed in the medical record for this example patient appears as: "Test, Richard ALMA"

- The name on their ID or insurance includes "Test" as the last name. "Richard" is the first name. And the name they use is "ALMA." The gender maker on file with insurance is M.
- We use ALL CAPS when someone's name is different from their legal name
- The patient portal reflects the medical record. Your name and other information, including gender marker, shows similarly there too.



We are happy to answer any questions you may have. If you need help with the registration form, please let the front desk know.