

Welcome to Whitman-Walker Health!

Whitman-Walker Health is a non-profit community health center focused on removing barriers to accessing care in the Washington, DC, metropolitan area. Whitman-Walker provides welcoming and supportive healthcare and services to gay, lesbian, transgender and gender expansive communities, people living with and affected by HIV and for anyone who wants to be seen for who they are in a setting where they can get the care they deserve. 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 care for.

This packet includes the following:

- Patient Registration
- SOGI Companion Resource
- Consents and Acknowledgement
- Patients Acknowledgement 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 name, gender, and pronouns. Please see the "SOGI Companion Resource" for more details. It also helps us comply with grants we apply for and provide services through. Please answer all the questions on the form including information about your annual income, family size, and housing. This information allows us to receive grant funding and serve you with affordable care.

This information is kept confidential and will become a part of your health record. 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 <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> They <input type="checkbox"/> Ze <input type="checkbox"/> Another:	
Date of Birth (mm/dd/yyyy)	Social Security #	

Address	City	State	Zip code
Is your housing? <input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Temporary <input type="checkbox"/> Homeless		DC Ward _____ <input type="checkbox"/> Don't know <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	<i>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.</i>		
Insurances we do not accept	<i>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.</i>		
#1 Insurance Company Name	Subscriber # <input type="checkbox"/> Employer Paid <input type="checkbox"/> Individual Paid	Group #	Contact # on back of card
#2 Insurance Company Name	Subscriber # <input type="checkbox"/> Employer Paid <input type="checkbox"/> Individual Paid	Group #	Contact # on back of card

Is the responsible party a Whitman-Walker patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> M <input type="checkbox"/> 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.

<p>What is your annual income?</p> <p>\$ _____</p> <p><input type="checkbox"/> No Income</p> <p>How many people (including you) does your income support? (Enter as least 1)</p> <p>_____</p>	<p>Racial Group(s) (check all that apply)</p> <p><input type="checkbox"/> African American/Black (including Africa, Caribbean)</p> <p><input type="checkbox"/> American Indian or Alaska Native (including all Original Peoples of the Americas)</p> <p><input type="checkbox"/> Asian (please specify)</p> <p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian</p> <p><input type="checkbox"/> Native Hawaiian/Pacific Islander (please specify)</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Other Pacific Islander</p> <p><input type="checkbox"/> White</p>
<p>Are you a Veteran of the US Military (NOT Active Duty)?</p> <p><input type="checkbox"/> Yes</p>	<p>Ethnicity</p> <p><input type="checkbox"/> Non-Hispanic/Non-Latino</p> <p><input type="checkbox"/> Hispanic/Latino(a) (please specify)</p> <p><input type="checkbox"/> Cuban</p> <p><input type="checkbox"/> Mexican, Mexican American, Chicano/a</p> <p><input type="checkbox"/> Puerto Rican</p> <p><input type="checkbox"/> Another Hispanic, Latino/a, Spanish Origin</p>
<p>Sexual Orientation</p> <p><input type="checkbox"/> Lesbian or Gay</p> <p><input type="checkbox"/> Straight or Heterosexual</p> <p><input type="checkbox"/> Bisexual</p> <p><input type="checkbox"/> Do not know</p> <p><input type="checkbox"/> Choose not to disclose</p> <p><input type="checkbox"/> Something else: _____</p>	<p>Preferred Language (choose one)</p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Amharic</p> <p><input type="checkbox"/> Other: _____</p> <p>Do you require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you are Deaf or Hard of Hearing, do you request:</p> <p><input type="checkbox"/> ASL Live Interpreter <input type="checkbox"/> ASL Video Remote Interpreter</p>
<p>How do you describe your Gender?</p> <p><input type="checkbox"/> Female/Woman</p> <p><input type="checkbox"/> Male/Man</p> <p><input type="checkbox"/> Trans woman or trans feminine</p> <p><input type="checkbox"/> Trans man or trans masculine</p> <p><input type="checkbox"/> Genderqueer/Non-binary/not exclusively male or female</p> <p><input type="checkbox"/> Choose not to disclose</p> <p><input type="checkbox"/> Another gender: _____</p>	<p>Do you identify as Trans or of Transgender experience?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>Sex Assigned at Birth</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Male</p>	<p>I attest the information on this form is correct to the best of my knowledge. I will update WWH if anything changes.</p> <p>_____</p> <p>Signature _____</p> <p>Date</p>



General Consents & Acknowledgements

For you to become a patient of Whitman-Walker Health (WWH), 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 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 (if 18 years or older) or consent for your child/minor for whom you have legal responsibility.

GENERAL CONSENT TO TREAT

I voluntarily agree to receive services from WWH, and I authorize the providers of WWH to provide such care, treatment, and/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 such things as tests, injections, and/or medications that are based on established medical criteria but are not free of risk. Additionally, 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. If there is an emergency, I know that someone at WWH may help me without waiting for me to authorize their assistance. I also understand that some services, such as a specific medical procedure, may require me to sign another consent form, so I may be asked to complete such forms later.

CONSENT TO RECEIVE SERVICES VIA TELEHEALTH

I acknowledge that telehealth services involve the use of electronic communications to enable my health care provider to evaluate, diagnose, and/or treat me from a remote location. Telehealth services may include video consultations, telephone calls, secure messaging, and other forms of communication. I understand that telehealth offers certain benefits including increased access to healthcare services, convenience, and reduced exposure to contagious illnesses. I also understand that telehealth has certain limitations and risks, including technical difficulties that may disrupt the consultation, limited ability for the provider to conduct a physical examination, and the potential for loss of privacy or security breaches in electronic communication. I understand that it is the role of my health care provider to determine whether or not the condition being presented, diagnosed and/or treated is appropriate for a telemedicine encounter. I release WWH from any loss of data or information due to technical failures associated with the telehealth/telemedicine service. I acknowledge that my provider may require an in-person examination before or after diagnosing or prescribing a treatment plan. I agree to assume certain responsibilities in the context of telehealth services, including ensuring a private and secure location for the telehealth consultation, providing accurate and complete medical and personal information to my provider, participating actively in the telehealth consultation, following my provider's instructions, and reporting any technical issues or concerns promptly to WWH.

NOTICE OF PRIVACY PRACTICES

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 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. I have had the chance to ask questions about WWH's Notice of Privacy Practices and understand and feel comfortable with the protections that it offers me.

INTEGRATED MODEL OF CARE

WWH offers a wide variety of services to its clients. I understand that 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 are regional health exchanges designed to 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 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 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 Patient 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 notice posted on bulletin boards at the health center. WWH has provided me information about being a patient at WWH including services offered, hours of operation and contact information. I agree to honor the stated Patient Responsibilities.

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 WWH.

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 various factors including 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 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 payment 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 and attest that I am age 18 or above, or that I am the parent or legal guardian of a minor patient.

Signature of Patient: _____ **Date:** _____

Printed Name of Patient: _____ **Date of Birth:** _____

If applicable, Printed Name of Parent/Legal Guardian: _____

If applicable, Relationship to Patient: _____

If applicable, Signature of Parent/Legal Guardian: _____ **Date:** _____

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:

Patient Rights and Responsibilities Statement

AS A WWH PATIENT, YOU HAVE THE RIGHT TO:

ACCESS SERVICES in a safe and respectful manner

- Receive services at WWH regardless of your race, color, religion, sex, marital status, sexual orientation, gender identity or expression, English language proficiency, national origin, age, disability, veteran status, or any other status protected by law.
- Receive respect and consideration from every employee, volunteer or trainee you interact with at WWH.
- Feel safe from harm and free from verbal, physical, or psychological abuse, intimidation or harassment when you are at WWH's facilities.

PRIVACY regarding your personal health information

- Expect WWH to comply with the Federal and State privacy laws when using or disclosing information about you or the health care and related services you receive at WWH.
- Receive a copy of WWH's Notice of Privacy Practices when you register as a new patient so that you will be more fully informed about your privacy rights.
- Active involvement in your ongoing care
- Help WWH providers and staff to develop a plan for the treatment and services you receive at WWH.
- Provide (or withhold) your consent to voluntary treatment, including your participation in clinical research, and be informed about the consequences of refusing any treatment or service.
- Provide WWH staff members with positive or negative feedback about your care, or voice your concerns or complaints about the Health Center.

TIMELY INFORMATION about your care

- Receive complete information about your diagnosis, and treatment or service plan in plain language that you can understand.
- Obtain a copy of your medical records upon request unless the law permits WWH to withhold the records.
- Receive an explanation of the costs associated with your care at WWH.
- Obtain assistance with referrals to other providers.

QUALITY SERVICES from our health center

- Receive coordinated health care treatment and services consistent with professional standards.
- Receive services from licensed and credentialed WWH providers.
- Request WWH to provide hearing, language, literacy or other communication assistance required by law.
- Receive services and care in the least restrictive environment feasible, free from chemical or physical restraints.

AS A WWH PATIENT, YOU ARE RESPONSIBLE FOR:

YOUR PERSONAL INTERACTIONS with our health center team

- Treat WWH employees, volunteers, trainees, contractors, other patients, and guests with respect at all times.
- Do not make any threatening or offensive statements at WWH's facilities.
- Do not engage in any act of physical violence or other threatening or inappropriate behavior at WWH's facilities, which includes bringing a weapon of any kind on site.
- Do not distribute or use alcohol or drugs on WWH's property or enter a WWH facility or program under the influence of illegal drugs or alcohol.

ACTIVE ENGAGEMENT in your care

- Take an active part in your treatment or service plan at WWH and stay in contact with your providers about your care.
- Request any hearing, language, literacy or other communications assistance you may need at least 48 hours prior to your visit.
- Show up for your appointments at least 15 minutes ahead of schedule and provide advance notice whenever it becomes necessary to cancel an appointment at WWH.
- Contribute to the cost of your care that the law or the health plan that you participate in require you to pay.

TIMELY INFORMATION sharing

- Provide WWH with complete, accurate, and truthful information at all times.

WWH's Patient Rights and Responsibilities Policy grants WWH discretion to take action placing limits on a patient's ability to receive treatment or services at WWH based on a patient's failure to meet their Responsibilities or for any other reason permitted by law. Likewise, any WWH patient has discretion to decide not to seek further treatment or services at WWH based on WWH's failure to abide by the patient Rights set forth in this Statement or for any other reason.

If you believe your rights as a Whitman-Walker Health patient have been violated...
please contact our Compliance Department at ☎ 202.745.7000.

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 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.

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 different 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.

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.

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 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.



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 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.



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.



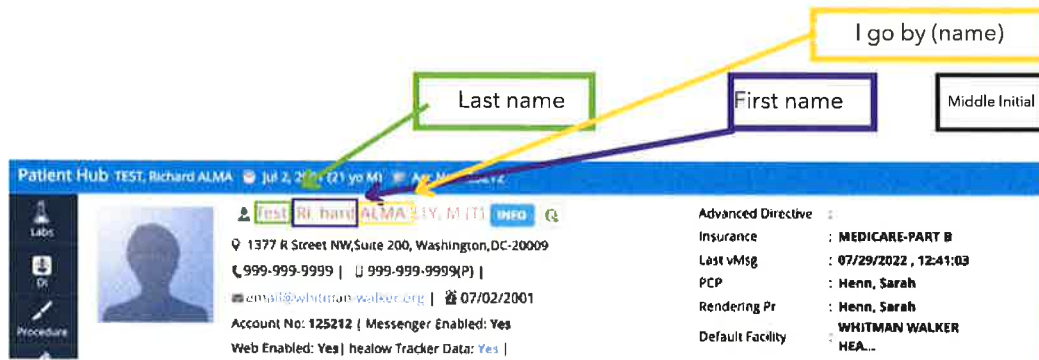


Why ask about my Name and what I go by?

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.

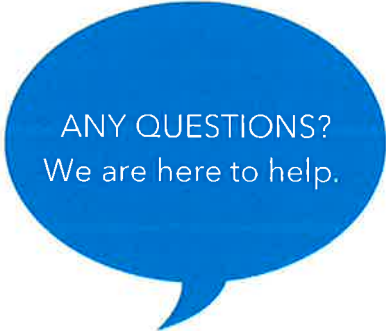


Why ask to select pronouns?

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:





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.

<p>Sexual Orientation</p> <p><input type="checkbox"/> Lesbian or Gay</p> <p><input type="checkbox"/> Straight or Heterosexual</p> <p><input type="checkbox"/> Bisexual</p> <p><input type="checkbox"/> Do not know</p> <p><input type="checkbox"/> Choose not to disclose</p> <p><input type="checkbox"/> Something else: _____</p>
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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.

<p>How do you describe your Gender?</p> <p><input type="checkbox"/> Female/Woman</p> <p><input type="checkbox"/> Male/Man</p> <p><input type="checkbox"/> Trans woman or trans feminine</p> <p><input type="checkbox"/> Trans man or trans masculine</p> <p><input type="checkbox"/> Genderqueer/Non-binary/not exclusively male or female</p> <p><input type="checkbox"/> Choose not to disclose</p> <p><input type="checkbox"/> Another gender: _____</p>



We see you.

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.

<p>Do you identify as Trans or of Transgender experience?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p> Test, Richard ALMA 21Y, M (T)</p>
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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.

<p>Sex Assigned at Birth</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Male</p>



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

 Test, Richard ALMA 21Y, M (T)

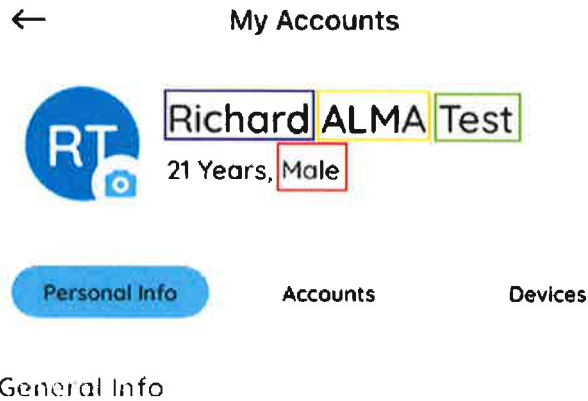


Here are a few things to know:

- 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 marker 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.