

## Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given access to a copy of the UCSF Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative. Also, a copy is posted on our website at [www.UBCP.org](http://www.UBCP.org).

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Printed Patient Name

Date of Birth (DOB)

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If Patient is a Minor, Printed Parent/Legal Guardian or Financial Guarantor Name

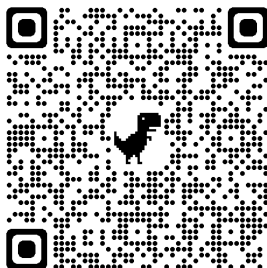
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Relationship to Patient

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Signature of Patient or Parent/Legal Guardian

Today's Date (Date Noticed Received)



You can scan here for access to the Notice of Privacy Practices



# We Ask Because We Care

Please complete this questionnaire. We use this information to review the treatment patients receive and to ensure that everyone gets the highest quality of care. Your individual responses are private and will not be shared outside the health care system.

1. Do you consider yourself Hispanic/Latino?  Yes  No  Decline to answer
2. How would you describe your Race? By race, we mean the major world group or groups from which your ancestors came. *Please check as many categories as you need to describe yourself.*

- |   |                                |  |
|---|--------------------------------|--|
| <input type="checkbox"/> American Indian/Alaska Native          | <input type="checkbox"/> Asian | <input type="checkbox"/> Decline to Answer |
| <input type="checkbox"/> African American/Black                 | <input type="checkbox"/> White | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Native Hawaiian/Other Pacific Islander |                                |  |

3. How would you describe your Ethnicity? By ethnicity, we mean the group or groups with whom you share your cultural identity or customs. *Please check as many categories as you need to describe yourself.*

- |   |   |
|---|---|
| <input type="checkbox"/> African  | <input type="checkbox"/> Japanese               |
| <input type="checkbox"/> African American/Black                                 | <input type="checkbox"/> Korean                 |
| <input type="checkbox"/> Alaska Native  | <input type="checkbox"/> Laotian                |
| <input type="checkbox"/> American Indian  | <input type="checkbox"/> Mexican                |
| <input type="checkbox"/> Arab/North African                                     | <input type="checkbox"/> Middle Eastern         |
| <input type="checkbox"/> Asian Indian   | <input type="checkbox"/> Mongolian              |
| <input type="checkbox"/> Cambodian  | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> First Nation (Canada)                                  | <input type="checkbox"/> Pacific Islander       |
| <input type="checkbox"/> Caribbean/West Indian                                  | <input type="checkbox"/> Russian                |
| <input type="checkbox"/> Central American                                       | <input type="checkbox"/> Samoan/American Samoan |
| <input type="checkbox"/> Chinese  | <input type="checkbox"/> South American         |
| <input type="checkbox"/> European/European Descent                              | <input type="checkbox"/> Thai                   |
| <input type="checkbox"/> Filipino   | <input type="checkbox"/> Tibetan                |
| <input type="checkbox"/> Guamanian  | <input type="checkbox"/> Tongan                 |
| <input type="checkbox"/> Hmong  | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Indigena - Maya  |   |
| <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other _____ |   |

4. In which state and/or country were you born? \_\_\_\_\_

**Please hand this form back to the front desk staff when completed. Thank you.**