



- Burlingame*    *San Francisco (Francisco St)*    *San Rafael*    *Menlo Atherton*
- San Francisco (325 Sacramento St)*    *Daly City*    *Beverly Hills*

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT  
PATIENT CONSENT FORM**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you or have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address listed above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Consent for Diagnostic Services:**

I have been informed of the reasons for this procedure. Understanding this, I authorize Health Diagnostics to perform the procedure.

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street address City State Zip

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business address: \_\_\_\_\_ Business phone: (\_\_\_\_\_) \_\_\_\_\_  
Street address City State Zip

Primary insurance: \_\_\_\_\_

Responsible Party/Subscriber Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_  
 (self, spouse, child if other please explain)

**Subscriber’s Date of Birth:** \_\_\_\_\_

**(Over)**

Emergency Contact information: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

I hereby authorize Health Diagnostics to obtain any medical information concerning: self or other (please circle) that is pertinent to the interpretation, evaluation and or performance of any radiological procedure provided by Health Diagnostics.

\_\_\_\_\_  
Patient or legally authorized individual signature      Date      Printed name if signed on behalf of the patient      Relationship (parent, legal guardian)

**Assignment of claim:**

I hereby authorize Health Diagnostics to furnish my insurance company all information which said insurance company may request concerning my medical condition. I hereby assign Health Diagnostics all payments for medical expenses, to which I am entitled, related to services provided. I understand I am financially responsible for charges not covered by my insurance.

**Financial Agreement:**

I understand that my estimated patient responsibility after insurance including deductible, co-pay and co-insurance is \$\_\_\_\_\_, and it is due at the time of service. I acknowledge that the above stated amount is only an estimate of the amount owed to Health Diagnostics for services rendered and only reflects the information that is available at the time of my signing this document. In the event that my payment results in an overpayment, Health Diagnostics will refund the amount of the overpayment. **If the amount due is actually greater than the amount listed above, I understand that I may receive a bill for the additional amount and I agree to pay such amount.**

I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to Health Diagnostics for charges not paid by my insurance. Any portion of charges not paid by my insurance company within 45 days of submission of the claim, regardless of the reason of any delay, will be billed to me and will then be due within 30 days of invoice. **I understand that Health Diagnostics will verify my insurance coverage; however, that this does not guarantee payment by my insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.**

Also, I understand there is a return check fee of \$25 if my check is returned for any reason and a late fee of up to **10%** of the outstanding balance may be charged. In addition, I understand I will be responsible for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

\_\_\_\_\_  
**Patient or legally authorized individual signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name if signed on behalf of the patient**

\_\_\_\_\_  
**Relationship (parent, legal guardian)**

**\*\*Daly City PET/CT patients only\*\***

Health Diagnostics participates with the National Oncologic Pet Registry, we require your authorization if you would like to participate. The National Oncologic Pet Registry was developed in response to the [Centers for Medicare and Medicaid Services](#) (CMS) proposal to expand coverage for positron emission tomography with F-18 fluorodeoxyglucose (PET) to include cancers and indications not presently eligible for Medicare reimbursement.

Yes I would like to participate in NOPR \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

No I do not want to participate in NOPR \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)