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**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 of 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 SFAMI to perform the procedure.

Patient Name: _____ Date of birth: _____ Age: _____

Patient Address: _____
Street address

_____ City State Zip

Phone: (_____) _____ SS#: _____ - _____ - _____

Employed by: _____ Occupation: _____

Business address: _____ Business phone: (_____) _____
Street address City State Zip

In case of emergency name of nearest relative: _____ Phone: (_____) _____

I hereby authorize SFAMI to obtain any medical information concerning myself/other _____
(State Patient Name and Relationship)

that is pertinent to the interpretation, evaluation and or performance of any radiological procedure provided by SFAMI.

(Over)

Assignment of claim:

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

Financial Agreement:

Private Pay: I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to SFAMI for charges not paid by my insurance. I understand this amount is due upon receipt of invoice.

Insurance Coverage: I certify that the information given to me in applying for payment under government or private insurance is correct. 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 SFAMI will verify my insurance coverage; but 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.

I understand a late fee of up to **10%** of the outstanding balance may be charged for late payment on invoiced charges. This is in addition to a charge 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)