



NORTHERN CALIFORNIA
PET Imaging Center

3195 Folsom Boulevard
Sacramento, CA 95816-5233
Phone: 916-737-3211
Fax: 916-737-6203
website: www.ncpic.org

PATIENT CONSENT

I hereby authorize my referring physician to release all medical information necessary to complete my medical care.

I hereby authorize the release of all medical information necessary to process this claim.

I hereby authorize payment of medical benefits directly to the physician or supplier of services itemized on said claim.

I understand that fees are subject to change based on actual exam(s) performed.

I understand that I am responsible for any charges or charge balances not paid by my insurance and agree to pay these amounts.

I understand that in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay for reasonable attorney fees or other such costs as the court determines proper.

Date: _____

Patient Signature / Responsible Party



**AUTHORIZATION FOR USE
OR DISCLOSURE OF HEALTH INFORMATION**

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize personnel of Northern California PET Imaging Center (“NCPIC”) to release to:

_____ *(persons/organizations authorized to receive the information)*

_____ *(address – street, city, state, zip code)*

The following information:

- a. All health information pertaining to my medical history, mental or physical condition, and treatment received
- OR
- Only the following records or types of health information (including any dates): _____
- b. I specifically authorize release of the following information (check as appropriate):
 - Mental health information
 - HIV test results
 - Alcohol / drug treatment information

PURPOSE

Purpose of requested use or disclosure: patient request **OR** other:

EXPIRATION

This authorization expires on _____ *(date)*



MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this Authorization at any time, but I must do so in writing and submit it to the following address:

Northern California PET Imaging Center
3195 Folsom Blvd.
Sacramento, CA 95816
Attn: Jeanette Galvan

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Date: _____ Time: _____ am / pm

Signature: _____
(patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient: _____

Witness: _____



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PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

You Have The Right To:

- Impartial access to treatment regardless of race, religion, gender, color, national origin, ethnicity, age, or disability.
- Respectful and considerate care.
- Know the names, titles, and qualifications of all who provide your care.
- Full consideration of privacy and confidentiality with regard to information and records of your care.
- Know and understand the diagnostic procedure of PET, including the benefits and any risks associated with the scanning process.
- Understand the sedation process and/or drug if prescribed by your physician for the procedure.
- Establish a self-pay program if authorization for the procedure is denied or if financial limitations of an insurance policy have been reached (except as prohibited by law).
- Examine and receive an explanation of your bills for service, regardless of the source of payment.
- Voice concerns and make suggestions regarding the center and/or the care provided including being informed of grievance procedures.

PATIENT RESPONSIBILITIES

You Have The Responsibility To:

- Respect the rights, property and environment of all physicians, health care professionals, employees and other patients.
- Know the benefits and the exclusions of your insurance coverage.
- Ask questions regarding the explanation given for any portion of the procedure that you do not understand.
- Report any adverse symptoms to the technologist during the scanning process.
- Adhere to the patient instructions provided prior to the procedure.
- Be responsible for the meeting the financial obligations of the procedure as promptly as possible. This may include the need to follow up as the member with your insurance company.
- Complete a charity care application if applying for financial coverage under the policy.

Signed: _____
Patient

Date: _____



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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices dated 12/08/2005. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by

e-mail at: _____

Patient Name: _____ Phone: _____

Signed: _____ Date: _____

Name of Guardian: _____

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Security / Privacy Officer: Ruth Tesar