

Patient Consent Form

Consent to Treatment

I hereby request and consent to treatment for myself or my child at Thyroid Center of San Francisco.

Initial of patient or guardian

Date

Medical Records Release

I authorize the release of any medical records or other information necessary for the processing of medical claims on behalf of myself or my child.

Initial of parent or guardian

Date

Insurance Appeals

I hereby consent for Thyroid Center of San Francisco to act on my behalf in pursuing any insurance appeals necessary to obtain payment for services rendered. I acknowledge that insurance appeal advocacy does not constitute legal representation, and that I may retain outside legal counsel to participate concurrently, if I so choose.

Initial of parent or guardian

Date

Financial Information

- Please be prepared to pay your co-payment at every visit. Your co-payment amount is usually indicated on your insurance I.D. card.
- Please be prepared to pay your deductible (if not met) and any co-insurance amount at the time of your visit.
- Please bring your current insurance I.D. card to every appointment. If you arrive for your appointment and we are unable to verify your insurance coverage or authorization, you may reschedule your appointment to a later date, or you may elect to keep your appointment that day, but will be required to pay for the visit. If you keep your appointment, we will make a reasonable attempt to bill your insurance and request a refund directly to you.
- If your insurance requires authorization from your primary care physician, please make sure that you have one that is valid for your visit and that it covers any necessary tests needed.
- We will be happy to bill your secondary insurance as a courtesy. If your insurance fails to pay within 30 days of the primary insurance payment, the balance will be forwarded to you.
- You may be responsible for services defined by your insurance as denied or non-covered.

Notice of Privacy Practice

Thyroid Center of San Francisco is committed to protecting the privacy of your medical and personal information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Thyroid Center of San Francisco protects your personal and health information in electronic, written, and oral forms when used throughout our organization. We may modify or change our privacy practices from time to time, particularly as new laws and regulations become effective. Any changes will be effective for all the personal and health information we maintain, even information in existence before the change. If we materially modify our privacy practices, we will provide you with a new notice advising you of the changes.

So that we may best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

I have read and understand the above information.

Written name of parent or guardian

Signature of patient or guardian

Date

Consent for Research

Thyroid Center of San Francisco is an integrated clinic dedicated to the centralized care of thyroid nodules. Our team is committed to achieving a higher standard of care for patients by bringing together experts in head and neck surgery, endocrinology, pathology, radiology, and nuclear medicine. Through this collaboration, we have the opportunity to contribute to the wider body of knowledge about the integrated evaluation, diagnosis, and treatment of thyroid nodules.

We request your consent to allow your Personal Health Information (PHI), records, and photo to be used for research and teaching purposes. Our practice adheres to all HIPAA standards regarding privacy. If you would like a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA notice that is available to you at the front desk and on our website. Be assured that this office will limit the release of all PHI to the minimum needed.

1. The patient agrees to allow Thyroid Center of San Francisco to use their Patient Health Information for the purpose of research, teaching, and pathology.
2. The patient agrees to allow their photo to be used for Thyroid Center of San Francisco materials.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Written Name of Patient

Signed Name of Patient

Date