*2970 Hilltop Mall Road, Suite# 103 • Richmond CA 94806 • 510-223-5122Ph 510-223-5125Fax*

# Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. We reserve the right to change our privacy practices, providing law permits such changes. Uses and Disclosures of Health information: We use and disclose health information about you for treatment, payment and healthcare operation. For example: Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: we may use and disclose your health information to obtain payment for services we provide to you. Healthcare operations: We may use and disclose your health information's in connection with our healthcare operations. Healthcare operations may include quality assessment and improvement activates accreditation. Certification, licensing, or credentialing activities. To your family and friends, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Persons involved in care: We will use our professional judgement and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up reports, medical supplies, x rays or other similar for, of health information, required by law: We may use or disclose your health information to remind you of appointment reminders such as voice mail, messages, email notification, postcards, letter, etc.

**PATIENT RIGHTS**: Access: You have the right to look at or get copies of your health information, with limited exceptions. You may obtain a form to request access to your records by using the contact information listed below., We will charge you a reasonable cost-based fee for expenses such as paper and film copies and staff time. ➡ **Initial here if you agree: ______________**

## ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT

**CONSENT FOR MEDICAL AND SURGICAL TREATMENT:** I authorize Hilltop Imaging and Diagnostic center (hereon will be called as HID) to furnish the necessary medical or surgical treatments, or procedures, including diagnostic and therapeutic medical imaging, and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or his designees. I am aware that the practice of medicine and surgery is not the exact science and I acknowledge that no guarantees have been made to me as to the result of treatment, diagnostic procedures in HID. I recognize that the physicians who practice at HID may not be employees or agents of HID and may be independent physicians. HID may delegate to these independent physicians those services physicians normally provide; and any questions relating to carte my physician has given or ordered should be directed to him/her.

**ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to HID of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially fully responsible to HID for changes not covered by this assignment. I also understand that HID is filing my claims as a courtesy to me and that unless stipulated in a contract with my carrier, I am fully responsible for the full payment balance of this claim. **AUTHORIZATION FOR RELATESE OF INFORMATION:** I hereby authorize HID to release any information regarding diagnosis and treatment requested by the insurance company necessary to collect benefits under the policies started at the time of treatment, or any policies which I subsequently make claim against for hospital services, including related physicians on this or related date of service. Unless noted below, this authorization includes but is not limited to, the lease of information related to drugs, alcohol, HIV, antibody and /or psychiatric treatment and or testing. Withhold from release: I further authorize any physician or institution that attended this patient previously to furnish medical records or information which may be requested by HID attending physician.

**LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries, or to the billing agent of HID any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in a place of the original, and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand d that I am responsible for any health deductibles and coinsurance. **MEDIGAP:** I request that they make payment of authorized Medigap benefits on my behalf to HID for any services furnished me. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. I understand that I do not need to provide any supplemental insurer with information concerning this Medicare claim, because any signing this authorization will name of insured **Medigap** Policy #:

**LIABILITY/INSURANCE WAIVER:** I hereby state that I wish HID to submit my claim for medical services to ____________ for services rendered for the accident date of ____/_____/____. I am not filing this claim with any other liability insurance and will not be making any claim to any other general liability insurance or company. I also understand that if I do submit this to any other general liability insurance company that _____________ will have to be refunded immediately and the total amount originally charged for the services rendered will become due and payable to me. Filing your liability insurance does not constitute an assignment. If this is a legal case, we do not accept assignment pending on the outcome of your case. You are responsible for your bill in its entirety.

**LIABILITY/ATTORNEY-MEDICAL RECORDS RELEASE:** I authorize HID to release my medical records to my attorney:
**Name**: ________________________ **Address**: ____________________________________________**Phone**: ___________________

**WORKER'S COMPENSATION:** This authorizes my physician to furnish written reports and communicate orally with any representative, attorney, or investigator from my Worker's Compensation carrier concerning my diagnosis, treatment, and prognosis sustained as a result of my Worker's Compensation injury.

**IF PATIENTS IS UNDER 19:** I hereby give my permission for (Child's name) _____________ to be treated at EDI

I read, comprehended and agreed with the above-mentioned material

**Patient's Name: ______________________ Patient's Signature: _____________________ Date:___________**