Consent & HIPAA

(2 signatures required)

SAN FRANCISCO
VOICE & SWALLOWING
KATHERINE C. YUNG, MD FACS

Consent to Treatment, Medical Records Release and Insurance Appeals

I hereby request and **consent to treatment** for myself or my child at San Francisco Voice & Swallowing.

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.

I hereby consent for San Francisco Voice & Swallowing 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.

X ______________________________ ______________

Signature of patient or parent/guardian Date

Financial Information

- Please be prepared to pay your co-payment and any outstanding balance at the time of your visit. You may be responsible for services defined by your insurance as denied or non-covered
- Please bring your current insurance I.D. card to every appointment. If 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. If you keep your appointment, you will be required to pay for the visit; we will make a reasonable attempt to bill your insurance and request a refund directly to you.

  If your insurance requires a referral 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.

Notice of Privacy Practices Acknowledgement

This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. It is available in print form at our front desk or electronic download on our website sfotomed.com.

By signing below, you acknowledge that:

- You have been provided with and understand that San Francisco Voice & Swallowing Notice of Privacy Practices provides a complete description of the uses and disclosures of your health information
- As part of your health care, San Francisco Voice & Swallowing originates and maintains health records describing your health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

  San Francisco Voice & Swallowing reserves the right to change its Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address you have provided, if requested.

  You have the right to review San Francisco Voice & Swallowing Notice of Privacy Practices prior to signing this acknowledgement

I have read and understood ALL the information on this page

X ______________________________ ______________

Signature of patient or parent/guardian ` Date

Cancellation/No Show Policy
and
Electronic Authorization

SAN FRANCISCO
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We strive to provide excellent medical care for all of our patients. In an effort to respect this level of care, we request that you cancel or reschedule your appointment **at least 24 hours in advance** of your scheduled appointment. **Effective September 1st, 2018**, we have implemented the following appointment Cancellation/No Show Policy below:

- We request that you cancel or reschedule your appointment **at least 24 hours in advance** of your scheduled appointment by contacting our office at 415.839.8639 or emailing frontdesk@sfvoice.com.
- If you fail to contact our office either via phone or email at least 24 hours in advance of your schedule appointment, this will constitute a cancelled/missed appointment.
    - If this is the first cancelled/missed appointment, then no fee will be charged.
    - Any subsequent cancelled/missed appointments will incur a **$50.00 no-show fee**.
- The $50.00 no-show fee is directly charged to the patient – not the insurance company – and will be **electronically charged** (per the authorized credit card) at the time of the missed appointment.
- If you are a new and/or existing patient and we do not possess your payment method on file, then we will require your credit card before attempting to reschedule your next appointment.
    - In order to be retained on file, your credit card will be charged a **one-time fee of $1.00**. This fee will then be applied - **once** - either to your next co-payment or billing invoice.
    - This one-time fee of $1.00 can be waived if you choose to pay your co-payment with the same credit card that will be stored on file.
- New and/or existing patients who are no show/cancel three consecutive appointments will be required to have a credit card on file before any future appointments can be scheduled.
- As a courtesy, when time allows, our office sends reminder emails regarding upcoming scheduled appointments. Ultimately, it is the patient's responsibility to remember their scheduled appointments. Therefore, if you do not receive a reminder email/message, the above policy will remain in effect.

If there is an unforeseen emergency and/or extenuating circumstances, then please contact our office within 24 hours of your scheduled appointment. We may be able to waive the no-show fee.

I authorize San Francisco Voice & Swallowing to keep my signature on file and to store/charge my credit card as a one-time storage fee of $1.00. I also authorize San Francisco Voice & Swallowing to charge my credit card a one-time $50.00 no-show fee per missed appointment. I understand this authorization is valid unless I cancel said authorization by written notice. I assume full responsibility for paying my charges in full at the time of service or making alternative arrangements for payment.

I have read and understood ALL the information on this page and agree to the terms of this policy.

X ______________________________ ______________

Signature of patient or parent/guardian Date