Tom H. Piatt, M.D. Inc Tate Diagnostic, Inc. 88____________**STKN / MTCA**

HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Private Practices: You have the right to read our Notice of Private Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. Please read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact person: CATHERINE TATE,PRESIDENT Telephone:[209]952-9300 Fax:[209]952-9191 Address: 3031 W. March Lane #336E Stockton, Ca 95219

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, ____ (**PRINT**), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ____ **Date:** ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal representative's name: ______________________________________ Relationship to patient: _______________
YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

We ask all patients to show their insurance or managed care membership card so that we may make copies of them. We **cannot** render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for the payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient's account.

PAYMENT AUTHORIZATION INS______________________________________

I, ____________________________________ (**PRINT**), hereby authorize **TOM H. PIATT, M.D. INC.** to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him/her as a result of the claim. Although covered by insurance, I am aware that I am personally responsible for all changes. A photostatic copy of this authorization will be as valid as the original.

Signature of Patient: ____ **Date:** ____________________**TECH:**________________

ABDOMEN 76700 & 76775 Dx____________	**RENAL 76770,51798 &76856 Auth** Dx____________	BREAST 76645 Dx____________	PELVIC (w/tv) 76856 & 76830 Dx____________	PELVIC (no tv) 76856 Dx____________	Fetal Outflow CMSP 76825 & 76811 655.93
OB. FULL 76811 Dx____________	**OB.F w/UMB 76811 & 76820 656. 53 Auth**	OB. F. TWINS 76811 & 76812 651.03	OB. LIM (no tv) 76801 Dx____________	OB. LIM CMSP/PREM 76815 Dx____________	OB. LIM (w/tv) **CMSP/PREM** 76815 & 76817 640.03
OB. TV 76817 Dx____________	**OB. F w/ BIO 76811 & 76819 Auth** Dx____________	OB. LIM TWINS 76801 & 76802 651.03	NT 76813 V28.89	NT Twins 76813 & 76814 V28.89 &651.03	
DVT 93970 Auth Dx____________	THYROID 76536 Dx____________	**CAROTID 93880 Auth** Dx____________	SCROTUM 76870 Dx____________	Dexa 77080 Dx____________	

LOG ______________ SC________________ CHARGED _______________ BILLED ____________ PMT ______________

Get 3D Photo's with your Diagnostic Exam.

_______ 3D/4D/HDLive $75.00/$95.00

- 3D/4D ultrasound with your Diagnostic ultrasound
- DVD recording of the exam*
- 2 3D color photos
- 4 3D black and white photos

_______ HDGender $50.00

- Gender determination 12-15 weeks
- 2 black and white photos

I am aware sonographer will **NOT** be providing any results today. All results have to come from doctor directly _______ initial

_______ USB/FLASH DRIVE $20.00

- Includes all of the photos taken during the exam

THIS IS NOT REQUIRED FOR YOUR MEDICAL EXAM.

________ I understand this is not required but my choice. This is a non-refundable addition to your medical exam. Tate Diagnostic cannot guarantee the clarity of your pictures. This will depend on baby's position, amniotic fluid volume, and echogenicity of the patient.

________ No thank you. I would just like the 2 black and white 2D photos that you have included with my diagnostic exam.

*Thank you, for choosing Tate Diagnostic for your ob ultrasound.*Prices and Packages subject to change without notice**

I consent that the video recording may include an audio narration of my voice and the voices of my guests,* ***conditions permitting, sometimes NO sound will be recorded at all**. Sometimes, due to the positioning of the baby (e.g. head down, low in the pelvis, facing mother's spine and stationary) or hands, feet or umbilical cord over the face,* ***Tate Diagnostic, Inc. can't guarantee a clear image of the face during a specific exam.*** *The quality of the 3D/4D images will vary from good to breathtaking. The variation will be due to the positioning of the baby, amount of amniotic fluid (more is better), how mother's placenta and uterus lie, and mother's echogenicity. Tate Diagnostic, Inc. will try to collect memorable images of the face, the hands, the legs, the feet and the genitalia (if you want to know).*

LAST NAME: ____________________________________ **FIRST NAME:** ____

DOB: __________/___________________/______________ **SSN#:** ________________ - ______________ -_______________

ADDRESS: ____**CITY:** ________________________**ZIP CODE:** ____________

TEL: (_________) ___________________________ **EMAIL:** ____

REF MD: ____ **ESTIMATED DUE DATE:** _____/________/_______

PRIMARY INSURED NAME: ____DOB:_____/_____/_____ SSN: ______-______-______

NEW PT: _________PREVIOUS BALANCE: ____PT PAID $_________________

HIPAA - Tate Diagnostic, Inc.

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SIGNATURE

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Signature:___________________________________ Date:_______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representatives name:____
Relationship to patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient’s chart.