Kidney Care Consultants, P.C.

CONSENT FOR CARE

I hereby give my consent for treatment to Kidney Care Consultant, P.C. Provider Dr. _____

Signature:_____ Relationship:_____ Date:_____
(Patient, Parent or Guardian)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS

I hereby authorize payment to Kidney Care Consultants, P.C. for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balances not covered by insurance, the deductible, co-insurance amounts and/or collection costs and legal fees incurred in an attempt to collect said balance.

Signature:_____ Relationship:_____ Date:_____
(Patient, Parent or Guardian)

LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kidney Care Consultants PC for services furnished to me by that provider. I also authorize any holder of medical information about me to release to the center for Medicare/Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature:_____ Relationship:_____ Date:_____
(Patient, Parent or Guardian)

AUTHORIZATION TO LEAVE MESSAGE

I hereby authorize Kidney Care Consultants, P.C. to leave a message regarding pending appointments/or tests results at my residence. ____ yes _____ no. It is ok to leave a message with my employer _____ yes _____ no.

It is ok to leave a message with family member: _____ phone number _____

Signature:_____ Relationship:_____ Date:_____
(Patient, Parent or Guardian)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received a copy of the notice of privacy practices as required by HIPAA Privacy Regulations that was published and first became effective on April 2003.

Signature:_____ Relationship:_____ Date:_____
(Patient, Parent or Guardian)