PAYMENT AT THE TIME OF SERVICE

It is our office policy that payments are due at the time of service. If we have a contract with your insurance company, we will file with your insurance on your behalf. However, YOU are responsible for all co pays, deductibles, and/or non-covered services at the time of service. It is also your responsibility to make sure you have a valid referral and/or authorization on file with your insurance company for dates of service billed on your behalf.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the information provided to the office is the most recent insurance information and it is true and correct to the best of my knowledge. I will notify you of any changes in this information. A photocopy or other reproduction of this will be as valid as original.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Clinic For Kidney Disease, P.A. to furnish my insurance companies, hospitals, referring or consulting physicians and billing agents, all information with regard to my medical care.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Clinic For Kidney Diseases, P.A. for medical benefits, if any, otherwise payable to me under the terms of my insurance.

I consent to receive medical care from the Clinic For Kidney Diseases, P.A.

Date: _____

Signature: _____
(responsible party if minor)

Print Name: _____