

TREATMENT CONSENT, PAYMENT AGREEMENT, AND INSURANCE RELEASE (ALL PATIENTS)

Patient Name: _____ Birthday: _____ Social Security #: _____

1. I hereby give consent for treatment of the above-named patient by any physician or other medical personnel providing services on behalf of Central Texas Nephrology Associates, P.A.
2. I understand that I am responsible for all charges incurred as a result of such treatment as well as those incurred in collecting for treatment charges. I realize that even though I may have insurance coverage, I am still responsible for payment. If legal action is instituted for payment of such treatment and/or services, I agree to pay reasonable attorney fees and all costs incurred herein.
3. Practice policy is that payment for services is expected at the time of treatment.
4. I authorize the release of any medical information necessary to process my insurance claim.
5. I request payment of benefits directly paid to my health care provider.
6. I authorize the use of this signature on all of my insurance claims submitted for me by my physician.
7. I authorize and request the release of all medical records to/from Central Texas Nephrology Associates concerning my illness and/or treatment from my primary care/referring physician from all legal responsibility that may arise from my authorization.
8. I authorize the release of my medication history to Central Texas Nephrology Associates.

Signature of Patient or Guardian: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR 2 YEARS FROM THE ABOVE DATE UNLESS REVOKED IN WRITING.

The Central Texas Nephrology Associates, P.A. **Notice of Privacy Practices**, is posted and available upon request. I have had the opportunity to read the copy and ask questions.

Signature of Patient or Guardian: _____ Date: _____

Personal Representative Signature (if applicable): _____ Relationship to Patient: _____

Please have current insurance cards available for our office to have a copy. If you do not have a card, fill out the information below.

Primary Insurance: _____ Insurance Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____ Effective Date: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Secondary Insurance: _____ Insurance Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____ Effective Date: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____