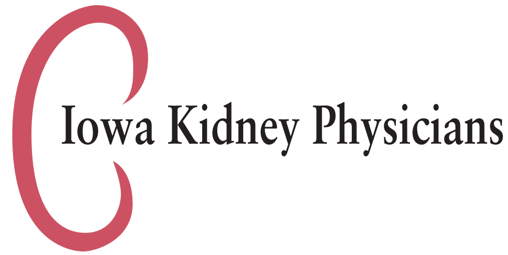

CONSENT / RECORDS RELEASE / ACKNOWLEDGMENT

CONSENT TO TREAT

I request and give my consent to medical care and treatment from Iowa Kidney Physicians PC and healthcare workers. I understand this includes and is not limited to diagnostic procedures, screening procedures, pathology services, and radiology services. I agree that photographs may be taken of me and used for my treatment or identification purposes.

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay Iowa Kidney Physicians PC its usual charges for all services received through Iowa Kidney Physicians PC, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Iowa Kidney Physicians PC, and direct that payment of proceeds be made directly to Iowa Kidney Physicians PC.

RECORDS RELEASE FOR CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof to any insurance company or third party payer for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

My Signature below represents I have read and understand the terms and statements above.

This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Patient Name (please print): ______________________ Date of Birth: ______/______/______

Patient Signature: ______________________ Date ______/______/______

Parent/Guardian's Signature: ______________________

Relationship to patient: ______________________

ACKNOWLEDGMENT OF PRIVACY PRACTICES RECEIPT

☐ I have been given a brochure on Notice of Privacy Practices:

______________________ Patient or Guardian Signature

______________________ Date

☐ I do not want a brochure on Notice of Privacy Practices:

______________________ Patient or Guardian Signature

______________________ Date

Iowa Kidney Physicians, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-515-241-5710.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-515-241-5710。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-515-241-5710.