Advanced Kidney Care of North Texas

GENERAL CONSENT, ASSIGNMENT OF BENFITS, FINANCIAL RESPONSIBILITY & DISCLOSURES

General Consent I consent to allowing Advanced Kidney Care of North Texas, Scott Biedermann, MD; Jessie George, MD; Alice Hsu, MD; John Hartono, MD; Samitha Reddy, MD; Hao Liu, MD; Theresa Carlson, AGACNP; Janette Gasaway, FNP; and any other affiliated professionals to provide me with necessary medical service, evaluation, diagnosis, treatment, and care. The duration of this consent is indefinite and continues until revoked in writing.

Assignment of Insurance Benefits I hereby authorize direct payment of my insurance benefits to Advanced Kidney Care of North Texas for services rendered to me. I further authorize Advanced Kidney Care to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier.

Financial Responsibility I understand and agree that I will be financially responsible for charges not paid by my insurance for services rendered. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, or coinsurance and that all amounts are due upon request and payable to Advanced Kidney Care of North Texas. I understand and agree that it is my responsibility to know if the physician or provider I am seeing is contracted in-network with my insurance plan. If the physician or provider I am seeing is out of network with my insurance plan, it may result in claims being denied or higher out of pocket expense to me. A copy of the Billing Policy (*Notice of Billing Policy*) is available for review on our website and posted in the waiting room at each office location.

Notice of Privacy Practices I acknowledge that I have received Advanced Kidney Care's *Notice of Privacy Practices.* This notice explains how my medical information may be used and disclosed. It also describes my individual privacy rights and certain obligations Advanced Kidney Care has regarding the use and disclosure of my medical information.

I understand that the *Notice of Privacy Practices* and the *Notice of Billing Policy* can change from time to time, and that I can obtain a current copy of this notice by accessing it online via our website: www.akcnt.com, contacting the office, or I can request a copy at the time of my visit.

_____

Signature of Patient, Parent or Legal Guardian Date

Patient Name (Print):_____DOB:_____