Consent to Treat

Name:
Medical Record Number:
Date of Birth:
Age:
Sex:

Consent to Treat and Notice of Privacy Practices

I understand that I am responsible for payment for all services rendered. I hereby assign and authorize direct payment of my medical benefits to Kidney Associates of the TriState. However, I understand and agree to pay all charges or amounts not timely paid by my insurance policy or plan including, but not limited to, any co-pays or deductibles. I acknowledge that it is my responsibility to know and understand the terms of my insurance policy or plan. I authorize Kidney Associates of the TriState to release all of my medical and other information to third-party payers, benefit administrators, or other persons as necessary to verify benefits to authorize medical services to be received, to process claims for benefits, to represent me in a third-party payer's hearing or appeal process, and/or to collect any payments. I permit a copy of this authorization to be used in place of the original. I authorize the use of "signature on file" to be used in all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. In accordance with recognized coding standards, I understand that I may receive separate charges for procedures, physicals, and/or other problem-oriented treatment during a single visit.

I further authorize the access and release of my clinical and medication information for treatment by my Specialty Care Provider and to any and all providers involved in my care.

I acknowledge that I have read the Kidney Associates of the TriState Consent to Treat form and I have received a copy of the Kidney Associates of the Tristate Notice of Privacy Practices.

The beneficial capabilities of the EMR allow us to use a digital photo to visually identify our patient while reviewing a chart. KAT will only use your picture for identification purposes. Your picture will never be disclosed with any medical record release or shown to anyone other than KAT associates for identification.

I give my consent to Kidney Associates of the TriState to provide medical care and treatment to me as deemed necessary and proper by my physician. YES / NO

I authorize Kidney Associates of the TriState billing or my provider's office to contact me by my cell phone.
YES / NO

Signature of patient or patient representative
Date/Time:

Relationship of Representative to Patient: SELF / PARENT / GUARDIAN

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