KIDNEY DISEASE CONSULTANTS, P.C.

Welcome to our practice, we appreciate the opportunity to serve you. Our goal is to provide you with the best medical care possible. The information below is intended to ensure you are aware of certain treatment, financial and privacy policies. If you have any questions, please inform a member of our front desk.

Consent for Medical Treatment and Authorization to Release Medical Information

I hereby authorize examination and/or treatment by Dr. Adeleye or persons under his supervision.

I give Kidney Disease Consultants, PC. (KDC) permission to obtain and/or release medical records from/to any physician, pharmacy or healthcare facility that has assisted or will assist in my care.

Section II: Acknowledgement of Receipt of HIPAA

I acknowledge that I have received a copy of KDC Patient Agreement including the Notice of Privacy Practices for Protected Health Information. I have been given an opportunity to ask questions about this agreement and the privacy practices described therein.
I give permission for messages to be left on my answering machine/voicemail system and/or speak to a family member or other persons at my home if I am not available unless I have completed a ***Restriction Form*** which has been approved in writing by Kidney Disease Consultants, PC.

Section III: No Show Policy

A $50 service charge per visit will be applied to a patient's account if the patient is a no show and the appointment has not been cancelled with 24 hours of scheduled appointment time.

Section IV: Consent for Electronic Prescribing

I authorize the physicians and other appropriate licensed providers of KDC and other healthcare team to submit prescriptions to my pharmacy using secure e-prescribing software. I further authorize access to my medical history, prescription history and current medications for any and health care providers.

Section V: Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by KDC. I assign and authorize payments of medical insurance benefits to KDC directly and release of any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collecting this account to include attorney's fee, court costs and collection agency costs in the event of default of payment of charges. It is my responsibility to contact my insurance plan prior to treatment at KDC.

If my insurance plan requires a referral in order to be treated by KDC providers, it is my responsibility to obtain the referral prior to be treated by KDC. If a referral is required, and I fail to obtain one, I will be financially responsible for any services rendered.

KDC will submit a claim to my insurance company but will require payment of any unpaid deductible, copayments and coinsurance for services provided in the office at the time rendered. If I am without verified health insurance or a plan that KDC does not participate, I am required to pay in full at the time services are rendered. In the event my insurance company denies my claim or pays my claim as "out-of-network" I am responsible for the balance.
KDC accepts cash, checks, and bank debit cards, American Express, Discover, MasterCard and Visa. Each instance of a refund check is subject to a $35 processing fee.

Section VI: Uninsured and Self-Pay Patients

Do not let the lack of health care insurance deter you from seeking medical advice and treatment at our practice. An office visit Payment of $100.00 for new patients and $70.00 for subsequent visits, is due in full at the time services are rendered and any remaining costs will be billed to you accordingly. If you have financial constraints, payment arrangements can be made prior to your actual visit.

Section VII: Refunds

Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than $5.00 will not be issued unless specifically requested.

Name of Patient: _____ D.O.B. _____

Signature: _____ Date: _____

Revised 08/2014