KIDNEY SPECIALISTS
OF MINNESOTA

PATIENT AUTHORIZATION FORM

Patient Name: ____ Date of Birth: _________________
(First, Middle Initial, and Last Name)

I, THE UNDERSIGNED PATIENT, OR THE PARENT OR LEGAL GUARDIAN OF THE UNDERSIGNED PATIENT ON THEIR BEHALF, HEREBY AUTHORIZE SERVICES RENDERED TO ME BY KIDNEY SPECIALISTS OF MINNESOTA, P.A. ("KSM") AND AGREE TO PAY FOR SUCH SERVICES INCLUDING THOSE SERVICES CONSIDERED NON-COVERED OR DENIED BY MY INSURANCE COMPANY. I ALSO AUTHORIZE THOSE ITEMS INITIALED BELOW:

CONSENT TO TREATMENT: I authorize KSM, its physicians, and any employee working under the direction of the physician or providers working with KSM to provide medical care to me. This medical care may include services and supplies related to my health and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment. ____ Initials

GUARANTEE OF ACCOUNT: I understand that medical insurance policies are an arrangement between a health plan and myself. I understand that charges for some services may be more than what some health plans choose to call "usual and customary" and that unless I am covered by and in compliance with a health plan with which KSM has a participation agreement to provide covered services, that I am personally responsible for all charges applied to my account and even if I am covered, I remain liable for all copays and deductibles. ____ Initials

ASSIGNMENT OF BENEFITS: I hereby authorize Medicare benefits and other health plans to be paid on my behalf to KSM for any services furnished to me by KSM and its providers. I authorize KSM and any of its business associates to release to the Center for Medicare Medicaid and its agents or my health plan any information needed to determine these benefits or the benefits payable for related services. ____ Initials

RECORDS RELEASE: I hereby authorize the release of my information including protected health information and billing information to my referring doctor, doctors involved in my care, and my health plan. I hereby authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from KSM or any other provider, with KSM, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations. I hereby consent to a release of my protected health information and billing information as described above and for treatment, payment and healthcare operations. ____ Initials

Copies: I permit a copy of this authorization to be used in place of the original. ____ Initials

I understand the above and I have had the chance to ask questions. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to my revocation.

Authorized Signature (Patient or Legal Guardian): ____________________________ Date: ____________