Patient Registration and Consent Form

Patent Name: ________________________________ Date of Birth: ___________

PLEASE CHECK BOXES AND SIGN BELOW:

☐ **RECORDS RELEASE: I hereby authorize KSM to release and obtain my medical records including protected health information and billing information (Information") to my primary care, referring physicians and other providers involved in my care, Medicare, payer network organizations, health plans (including accountable care organizations) and their contractors, and third-party administrators as needed for treatment, payment and healthcare operations. I also authorize each of them to share my Information obtained from KSM with health information exchanges, accountable care organizations in which my provider participates, and with the contractors and third-party administrators of these parties as needed for treatment, payment and health care operations. I agree that is authorization shall continue for a period of ten years from the date of this authorization.**

☐ **EMR RELEASES: I hereby authorize KSM to share my Information obtained from KSM with healthcare providers other than KSM who utilize the same electronic medical record ("EMR") system subject to the requirements of and to the extent authorized under such EMR system. I agree that is authorization shall continue for a period of ten years from the date of this authorization.**

☐ **ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits to KSM for services rendered to myself and/or dependents in addition to authorizing KSM or my insurance company to release any information required to process my claim.**

☐ **MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to Kidney Specialist of MN for services furnished to me by a physician/clinic/supervisor of KSM. I authorize any holder of hospital or medical information about me to release to the center for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable to related services. I permit a copy of this authorization to be used in place of the original.**

☐ **MEDIGAP: I request that authorized MEDIGAP benefits be made on my behalf for services rendered to me. I authorize any holder of medical information to release to the applicable MEDIGAP carrier any information needed to determine these benefits**

payable for related services.

☐ 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 of review of mental status/functions 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 professions for care and treatment as well as a consent to communication and treatment through telemedicine.

☐ VERIFIED FACESHEET: I have reviewed the patient face sheet and verified my demographic and coverage information is correct. I agree to contact KSM if this information changes.

** Where may we leave a detailed voicemail (Please choose one) *

☐ HOME ☐ CELL ☐ WORK ☐ NONE

**In the above detailed voicemail, can test results be communicated (please check applicable box below) *

☐ Yes ☐ No

I permit a copy of the authorization to be used in place of the original. I agree that the authorizations and consents provided above shall be effective for a duration of ten years unless earlier terminated by written notice to:

Kidney Specialists of Minnesota, P.A.
Corporate Office
6200 Shingle Creek Pkwy, Suite 260
Minneapolis, MN 55430.

A copy of this signed document will be viewable on your MyChart and can be printed upon request.

Patient Signature

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