New York Kidney Physicians PLLC

www.nykp.care

Central Appointment : 347-460-4253, eFax **(718) 355-9650**, Ans Serv 888-456-4900

Last Name		First name	
Address		Apt	
City		State	NY Zip:
SSN		DOB	
Tel ---------- Mobile	----------	Email	
Emergency Contact		Relation	Number

Authorization To Bill Health Insurance/Assignment of Benefits/ Consent to Release Information

➤ ✔ I above named patient do hereby give full permission and authorize Queens Nephrology Associates, to bill my insurance company for services rendered by Queens Nephrology associates and health care providers. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to: Queens Nephrology Associates, 34-35 70th St, Jackson Hts, NY 11372 or its affiliated medical practice offices.

By signing this document I also agree to the following statements below: I understand that I am responsible for understanding information about my health insurance policy and providing such information to Queens Nephrology Associates, for correct billing. I am also responsible to notify Queens Nephrology Associates in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office. I understand that Queens Nephrology Associates will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at Queens Nephrology Associates during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at Queens Nephrology Associates, but that such benefits do not necessarily guarantee payment for those services. I understand that the policy of Queens Nephrology Associates requires payment in full or copay or deductible as per insurance for all services rendered at the time of visit, unless other financial arrangements have been made. If my account is not paid within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account (normal charge - 33% in addition to your outstanding balance due in our office). I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert Queens Nephrology Associates of any change in my medical status or insurance coverage. The undersigned does agree to observe and abide by all of the statements made above.

➤✔ Federal and state laws may permit this Medical Practice to participate in organizations with other healthcare providers, pharmacy, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this medical practice may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

➤ ✔ I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members. [Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.]

Note: This clinic uses an Electronic Health Record and do not maintain paper chart, that will update all your demographics-insurance to the information that you just provided. All document scanned and returned original to the patient.

➢ ✔ I consent to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

➢ ✔ Patients in our practice may be contacted via email listed above and/or text messaging on mobile above to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time.**The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).**

Print Name: _____ Relation :_____(if not the patient)

Patient/Patient Representative Signature:_____

Date: _____ Time: _____

Staff Action [ ] Scanned in Electronic health record and returned original to the patient.

Refusal of consent

_____ (Patient/ Representative Initials) I **do not consent** to receive communication via text or email or mail.

_____ (Patient/Representative Initials) I **do not consent** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Patient Name: _____

Patient/Patient Representative Signature:_____

Date: _____ Time: _____