RENAL MEDICINE ASSOCIATES

# Patient Informed Consent Form

Patient Name: _____

Last 4 of SSN: _____ DOB: _____

Address: _____

- I hereby understand that Renal Medicine Associates will file all my insurance claims, provided I inform them of the correct policy information and that I have a current referral or prior authorization from my primary care provider as required by my insurance carrier.
- I understand that I am financially responsible for all services provided.
- I request that payment be may to Renal Medicine Associates, LTD. on any billed services that are rendered to me.
- I have received a copy of the Notice of Privacy Practices. **Initial:** _____
- I give Renal Medicine Associates consent to run a Pharmacy History Report. **Initial:** _____

## Appointment Confirmation

I give Renal Medicine Associates permission to confirm my appointment forty-eight hours (48) in advance of my next appointment and/or I authorize representatives of Renal Medicine Associates to leave information on my home, mobile or work phone numbers. **Initial:** _____

I give Renal Medicine Associates permission to send correspondence via email. **Initial:** _____

I give Renal Medicine Associates permission to send text messages to my mobile phone. **Initial:** _____

★ Please keep in mind that a $30 fee may apply if you do not contact our office within twenty-four hours (24) to cancel a scheduled appointment.

## Authorizing Representative

1) _____ Relation: _____

2) _____ Relation: _____

**Patient Signature** (or Authorized Representative Signature)

_____ _____

Patient/Parent/Guardia/Authorized Representative Signature Date