The Centers for Kidney Care

Patient Authorization

Assignment of Benefits

_____ I certify that the information I have provided in applying for payment of Medicare/ Medicaid Insurance benefits are correct. I irrevocably assign benefits to The Centers for Kidney Care for the payment of services rendered. I understand it is my responsibility to comply with all pre-certification requirements and that I am responsible for any health insurance co-payments, co-insurance and deductibles.

Financial Responsibility

_____ I understand that insurance coverage is not a guarantee of payment and I agree that **I am ultimately responsible for the payment of services** rendered at The Centers for Kidney Care. I will honor the clinic's financial policy. If I cannot pay in full at the time of services, I agree to set up payment arrangements until my debt with The Centers for Kidney Care is paid in full.

Patient Consent – Authorization for Care

_____ I grant permission for The Centers for Kidney Care to render care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures. I understand that I may receive care and I consent to the care that is provided to me by a Nurse Practitioner (NP) and/or Physician Assistant (PA). I understand that a Nurse Practitioner and Physician Assistant are licensed professionals who work with The Centers for Kidney Care under the supervision of my physician and that they may discuss my care with my physician.

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Signature of Patient/Representative	Relationship to Patient	Date