The Center for Kidney Care

ASSIGNMENT OF BENEFITS

I, ___________________________request the payment of authorized insurance benefits to be made on my behalf to The Center for Kidney Care. I authorize Center for Kidney Care to release to my insurance company (s) and its agents any information needed to determine these benefits.

I understand my signature request that payment be made and authorizes the release of medical information necessary to pay the claims. My signature authorizes the release of information to my insurance company (s) or its agents.

(***) Medicare***: The Center for Kidney Care agrees to accept the charge determination of the Center for Medicare and Medicaid services or its agents as the full charge. The patient is responsible for the deductible, coinsurance, and non covered services. Coinsurance and deductible are based upon the charge determination of CMS or its agents.

(***) Medicare*** Supplement: Name of Carrier ____ Policy # _____________________

( ) ***Insurance***: Name of Carrier: ____

The patient is responsible for all deductibles, coinsurance, and non covered services. It is the patient's responsibility to secure all referrals and pre-approvals for services as outlined in the patient's insurance policy guidelines. Insurance coverage is a contract between the insured (patient) and the insurance company.

Patient Signature: ____ **Date:** ____________________________

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MEDICAL RELEASE AUTHORIZATION

I, ____, hereby authorize physicians, specialists and facilities who hold my medical records to release to The Center for Kidney Care, copies of my medical records. I understand this release includes primary care physicians, specialists, medical & diagnostic facilities. I further authorize the release of my insurance carrier and policy numbers to The Center for Kidney Care. I recognize that the sharing of this confidential information is solely and necessary to facilitate my medical care.

____ __________________________

Patient Signature **Patient Date of Birth**

____ __________________________

Patient Social Security Number **Witness Signature**

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Date