Dallas Renal Group

Patient Registration Form

Disclosures & Consents & Financial Responsibility Agreement

Patient Name: _____ **Date of Birth**: _____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Dallas Renal Group or the physician individually for services rendered to my dependents or me by the physician or under his-her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefit. I understand and agree that I will be responsible for any co-pay or balance due.

MEDICARE/ MEDICAID/ INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to the Dallas Renal Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Dallas Renal Group Patient Information Privacy Policy. I hereby authorize Dallas Renal Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize the Dallas Renal Group staff or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Dallas Renal Group to that effect in writing.

LAB/ X-RAY/ DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

FINANCIAL RESPONSIBILITY AGREEMENT
I understand and agree that I will be financially responsible for any and all charges not paid by my insurance for my visits. This includes medical service or visit, lab testing, and any other screening service or diagnostic ordered by the physician or staff. I understand and agree it is my responsibility and the responsibility of the physician or clinic to know if my insurance will pay for medical service or visit. I understand and agree it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, usual and customary limit and I agree to make full payment. I understand and agree it is my responsibility to know if the physician or provider I am seeing is contracted in-network with my insurance plan. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible and make full payment.

Patient signature: _____ **Date**: _____

Guarantor signature: _____ **Date**: _____
(If different from patient)

Guarantor name (please print): _____