KVA
KIDNEY & VASCULAR
ASSOCIATES

PATIENT CONSENT FORM

Please read this form carefully and sign where indicated. This consent is required to render medical services and to obtain payments from your insurance carrier(s). Please ask our staff members if you have any questions regarding the contents of this form.

Permission to Examine and Treat:
I hereby give my permission to Kidney & Vascular Associates, it's physicians, and staff to obtain medical history, carry out medical examination, and or procedures needed to make a diagnosis and offer medical treatment.

Refusal of Medical Treatment:
I understand that I have a right to refuse any and all medical treatments and recommendations. I shall take full responsibility of my actions in case of refusal of treatment or not following medical recommendations.

Financial Responsibility:
I understand that I am financially responsible for all the charges whether they are covered by insurance carrier(s). I also understand that some insurances do not cover routine examinations, annual physicals, school physicals, and third-party examinations. I agree to any co-payments, deductibles, and/or services not covered by my insurance carrier on the date of service.

Kidney and Vascular Associates will submit a claim to your insurance carrier(s) on your behalf, if correct insurance information is provided at the date of service. If we are unable to collect your outstanding debt within a reasonable time, we shall hand over your account to a collection agency and dismiss you as a patient of our medical practice.

Laboratory Tests and Services:
I authorize Kidney & Vascular Associates to send my blood / urine specimens to an outside laboratory for testing. I understand that I shall be financially responsible for payments of the laboratory services that are not covered by my insurance carrier(s). I understand that bills for unpaid laboratory services will come directly from the laboratory where the specimens were sent.

Assignment of Benefits:
I hereby assign, transfer, and set over Kidney and Vascular Associates all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. A photocopy of this document shall be considered as effective and valid as the original. Medicare assignment benefits will apply accordingly. This authorization shall remain valid until a written notice is given by revoking said authorization.

Authorization to Release Medical-related Information:
I authorize release of medical information needed to determine my medical reimbursement benefits. (Your insurance may request such information to prove that you were seen in the office. In Michigan, we are required to provide this by law)

Signature _____ Date_____

Relationship if you are guardian _____