TEXAS KIDNEY PARTNERS
2001 Auburn Hills Pkwy, Ste 801, McKinney, TX 75071, US
Phone: 469-613-2343 Fax:- 214-548-5535

Benefits Assignment and Financial Responsibility

Last name	First Name	DOB
Address		SSN

RELEASE OF INFORMATION: I authorize Texas Kidney Partners to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that COPAYMENT IS DUE AT THE TIME OF SERVICE (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to Texas Kidney Partners if this matter is referred to collection.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Patient Signature _____ Print name_____ Date _____

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Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.

a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.

a. I may revoke my right at any time by contacting Texas Kidney Partners at 2147968579.

5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.

a. I understand that my insurance carrier will have access to my medical records for quality review/audit.

b. I understand that I will be respnosibile for any out of pocket cost such as copayments or coinsurances that apply to my telemedicine visits

c. I understand that health plan payment policies for telemedicine visits may be different from policies for in person visit.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____
Patient/Parent/Guardian Printed Name

_____
Patient/Parent/Guardian Signature

_____
Witness Signature

_____
Date