

FRESNO NEPHROLOGY MEDICAL GROUP, INC.

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Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

ONE TIME AUTHORIZATION

Patient: _____
Last Name First Name MI Social Security Number

Address: _____
Street City State Zip Code Date of Birth

Primary Insurance: _____ **ID#:** _____

Secondary Insurance: _____ **ID#:** _____

ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare and/or all other insurance companies be made on my behalf to Fresno Nephrology Medical Group, Inc. (FNMG) for any services furnished to me by my physician (Steve W. Su, M.D., Steven B. Levy, M.D., Joseph C. Dufлот, M.D., Anuradha Suri, M.D., Harpreet S. Dhindsa, M.D., Yangming Cao, M.D., Mei-Tsuey Hwang, M.D., Hemant Dhingra, M.D., Mandeep Singh M.D., or Sukhvир Atwal, M.D.). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent and /or any insurance company any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay this claim. In Medicare and other insurance carrier assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Insurance carrier as the full charge, and the patient is responsible for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the insurance carrier.

A photocopy of this authorization is considered valid.

Further use or disclosure of the information being released beyond the specific limits of this consent is prohibited.

Signature of Patient or Authorized Person Relationship To Patient Date

FINANCIAL AGREEMENT: I, the undersigned, agree whether I am signing as an agent or as the patient, that I am financially responsible for any charges not covered by the insurance assignment(s). It is understood and agreed by all parties that if FNMG is contracted with my insurance carrier, I am only responsible for my co-payment and/or deductible as contracted. If there is no insurance coverage/or eligibility I will be responsible for all charges.

A photocopy of this authorization is considered valid.

Further use or disclosure of the information being released beyond the specific limits of this consent is prohibited.

Signature of Patient or Authorized Person Relationship to Patient Date

Signature of Witness Title of Witness Date