

RENAL MEDICAL ASSOCIATES, P.C.

General Patient Consent for Care

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Renal Medical Associate on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Renal Medical Associates is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Renal Medical Associates, P.C. facilities.

Electronic Health Records / Telemedicine:

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. I understand that my provider might ask to record the visit for documentation purposes. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

To the Patient:

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. By signing below, you are indicating that (1) you intend that this consent continues in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services with our practice at any time.

Cancellation and Missed Appointment Policy:

Effective 07/01/2025 Renal Medical Associates will require a 48-hour notice of appointment cancellation. I understand that if there is failure of proper notification of a cancelled or missed appointment I could be charged a \$50.00 fee. Fees for missed appointments are not covered by insurance. Our practice is aware that there are unavoidable circumstances that occur and will take that into consideration once speaking with the patient.

Interpretive Services (verbal and/or sign language):

Our practice is obligated to provide interpretive services to any patient who requires assistance. I understand that Renal Medical staff must have time to arrange interpretive services (spoken or sign language) and I will try to provide as much notice as possible about cancelling or rescheduling appointments to allow time for the interpretive service to be contacted. I am aware there is a \$50.00 timely cancellation and/or missed appointment fee which applies to all patients in the collation and missed appointment policy detailed above.

Authorization and Assignment Consent for Insurance Companies, Medicare, and Medicaid:

Medicare/Medicaid Patients: I request payment of authorized Medicare/TennCare benefits be made to Renal Medical Associates, P.C. for any services provided to me by Renal medical Associates P.C. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits payable for services rendered. I authorize the release of any information necessary to determine liability for payment, to obtain reimbursement on any claim, and to allow a photocopy of my signature to be used to process insurance claims.

I assume financial responsibility for any unpaid charges/balances for services provided to me by Renal Medical Associates, P.C. In the event my account is placed for collection, a collection fee will be added to my account balance at the time it is placed with a collection agency.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to the contents.

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Legal Guardian

Relationship to Patient