ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

1. **Assignment of Benefits and Related Release of Information.** I request payment of authorized benefits directly to the provider for services furnished to me at this facility. I consent to the release of medical and other information related to such services for healthcare operations and to Medicare, my insurance company, HMO, other third party payers, or their third party administrators, in order to process and pay claims, determine benefits and perform quality of care reviews.
2. **Release of Information to Health Care Providers.** I consent to the release of my health records created, received and maintained by Associated Nephrology Consultants, PA for my treatment to other health care providers who are involved in my treatment. This consent does NOT include release of information obtained by or created in a drug or alcohol abuse treatment unit.
3. **Important Information for Patients.** Initial Received

_____ Notice of Privacy Practices (unless received during previous visit)

This consent will continue forever unless you cancel it by writing us at: Associated Nephrology Consultants, PA, 1997 Sloan Place, Ste 17, Maplewood, MN 55117; but if consent is cancelled, it will not change releases that have already been made.

_____ _____

Signature of Patient, or if Patient is unable to sign, a Representative of the Patient — Date

_____ _____

Relationship to Patient (if patient is unable to sign) — Reason Patient Unable to Sign

4. **Guarantee and Agreement to Pay**

NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below.

I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that 6% interest per year may be added if the account balance goes to a collection agency.

_____ _____

Patient, Legal Representative or Guarantor Signature — Date

☐ Directed by Patient to sign on their behalf (having read this document to them)