NEPHROLOGY
ASSOCIATES OF SYRACUSE, P.C.

PATIENT CONSENT

CONSENT TO DIAGNOSTIC AND MEDICAL TREATMENT

I understand that I have a condition that requires medical care and give permission for such care at Nephrology Associates of Syracuse, PC. I also understand that this care may include diagnostic lab procedures and medical treatment.

As part of this care, I give consent for any blood or urine to be used for diagnosis or treatment.

No promises have been made to me about the result of treatments or examinations that I will have while I am at Nephrology Associates of Syracuse, PC.

I agree to allow Nephrology Associates of Syracuse, PC to disclose my protected health information to the individual(s) I identify as my designated care giver.

I understand and provide authorization for NAS to record and enter the name(s) and phone number(s) of the Emergency Contact(s) that I provide into my patient record. I agree to notify NAS if I wish to make changes to my Emergency Contact(s) and agree to keep this information current.

COMMUNICATIONS, ADMINISTRATION, TELEMEDICINE & SCRIBE SERVICES

EMERGENCY CONTACT/NAME OF INDVIDUAL(s) WE CAN SHARE INFORMATION WITH:

COMMUNICATIONS

I authorize NAS to leave phone messages pertaining to appointments or payment issues, and to send correspondence to the address provided for the insurance holder unless other arrangements are made in advance. I understand that NAS will utilize phone calls, text messages &/or emails to notify patients about future appointments and other important notifications. I consent to the release of any medical information about me and any other individual for whom I give consent to my health plan and any health care providers involved in caring for me or such individual, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations. I acknowledge that I have a right to request a chaperone for

today's office visit or any future visits with NAS. I have been offered or received a copy of the Notice of Privacy Practices.

NAS offers several convenient electronic tools as an opportunity for patients to be actively engaged in their health care. The *Patient Portal* is available via our web site at www.nephrologysyracuse.com. We also offer the mobile *Healow App*, which can be downloaded to your smart phone. Both the *Patient Portal* and *Healow App* are helpful and convenient alternatives to phone call communication with NAS. You may send non-urgent messages, request prescription refills, view labs that have been performed on-site at NAS and that your provider has reviewed, request to reschedule an appointment, pay your bill on-line and more.

APPOINTMENT REMINDERS, NOTICE OF CANCELLATION POLICY AND NO-SHOW FEES

At NAS, we remind you of your scheduled office appointment either by text, email, or phone. We understand that there are times when you must miss an appointment due to an emergency, or family or work obligation. If you cannot make your appointment, we ask that you please contact us at least 24 hours ahead of time to reschedule your appointment.

Methods to contact us include responding to a phone call or text notice, or a phone call to our office during normal business hours (Monday – Friday 8:00 am - 4:00 pm).

Patients who fail to show up for their appointments or cancel less than 24 hours in advance may be charged a No-Show Fee that is not covered by insurance. This fee may be required to be paid prior to scheduling further appointments at the practice. Multiple no-show or cancelled appointments may lead to dismissal from the practice. *We require that all active patients have a scheduled appointment to ensure that they are not lost to follow-up care.* I have read and understand the policy NAS has regarding no shows and cancellations.

PATIENT CONSENT FOR TELEMEDICINE AND SCRIBE SERVICES

As permitted by federal and state guidelines, telemedicine services may be a health care option for NAS patients. NAS will follow all federal and state guidelines and requirements. I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and herby consent to NAS providing health care services to me via telemedicine. I understand that laws that protect privacy and confidentiality of medical information also apply to telemedicine and that my insurance carrier will have access to my medical records for quality review/audit. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my treatment at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Nephrology Associates of Syracuse at 315-478-3311. As long as this consent is in force (has not been revoked) NAS may provide health care services to me via telemedicine without the need for me to sign another consent form.

I understand that various providers may use HIPAA compliant virtual medical scribing services that will assist in documenting the patient visit through secure recorded encounters. This data is encrypted in compliance with federal and state regulations.

FINANCIAL CONSENT & ASSIGNMENT OF BENEFITS

Thank you for choosing NEPHROLOGY ASSOCIATES OF SYRACUSE, PC (NAS) to be your Provider. As a patient, you have certain responsibilities in regard to your insurance contract(s):

1.) To pay amounts not covered by your policy, including applicable copays, co-insurance, and deductibles.

2.) To be knowledgeable about your plan's covered and non-covered services.

3.) To provide NAS with accurate and up to date insurance coverage.

By signing this agreement, you agree to be billed as a self-pay patient should you fail to supply valid, accurate insurance information at the time of service.

Due to strict timely filing rules and government regulations, you also agree to notify us right away- no later than 30 days, after you receive notification that you are eligible for additional coverage(s) including Medicaid, Medicare, Medicare Advantage plans or other supplemental policies. Should you fail to give us timely notification of additional coverage (including Medicaid or Medicare eligibility), you will be considered a self-pay patient and agree to be held responsible for payment of your charges.

Payment is expected at the time of service. If full payment is not possible at the time of service, a partial payment is expected. Payment plans may be set up on an individual basis with our Billing Office by calling (315) 362-5287 Monday – Friday from 9 am – 3 pm EST. Please provide current insurance identification card (s) and valid identification at each visit, and please keep us updated on the best way to reach you via phone, your current cell phone number and mailing address.

INSURANCE & PAYMENTS - It is your responsibility to find out if NAS participates with your insurance company. Each insurance company has many plans that can vary even within one

employer. We have a list of participating insurance carriers on our website at www.nephrologysyracuse.com. Whatever is not covered by your insurance plan(s) is your responsibility. You must present your insurance card(s) at each visit. Your co-pay is due at the time of service. We accept cash, checks, money orders, and credit cards.

ASSIGNMENT OF BENEFITS

I hereby authorize NAS to release all information necessary to complete insurance forms and to secure payment. I also authorize payment for medical services to be sent directly to NAS. I hereby authorize NAS to place my signature on file with Upstate Medicare Claims Division for the purpose of billing Medicare. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I accept responsibility for all medical charges not covered by insurance. I agree to pay any co-pays and/or balances at the time of service unless other arrangements are made in advance. I accept financial responsibility. Correspondence regarding medical charges will be sent to the address of the insurance holder. I assume responsibility for all reasonable collection costs, including attorneys' fees.

After services are rendered, I understand that a claim will be submitted to my insurance carrier for payment, and further, submission of a claim is not a guarantee of payment.

I certify that I have read the above and understand its contents.

Date

Signature of Patient or Legal Guardian

Relationship to Patient