NEPHROLOGY ASSOCIATES OF SYRACUSE, PC

Philip T. Ondocin, MD
Matthew G. Chaffin, MD
Simardeep S. Mangat, MD
Bala K. Murthy, MD
Antoine Azar, MD

Marcia H. Ryder, RN, NP
Jacquelyn A. Spencer, RN, NP
Alyssa C. Miles, PA
Tracy A. O'Neill, PA
Maureen Lupica, NP
Hannah Huang, PA

Anne E. Zaccheo, MBA, FACMPE
Practice Director

2026 Patient Financial & Administrative Consent

Consent to Diagnostic and Medical Treatment

I understand that I have a medical condition requiring evaluation and care and hereby give my consent to receive medical services at **Nephrology Associates of Syracuse, PC (NAS)**. I understand that my care may include diagnostic testing, laboratory procedures, and medical treatment as determined appropriate by my provider.

As part of my care, I consent to the collection and use of blood, urine, or other specimens for diagnostic and treatment purposes.

I understand that no guarantees or promises have been made regarding the results of any examinations or treatments I may receive at NAS.

I authorize NAS to disclose my protected health information to the individual(s) I identify as my designated caregiver(s), as permitted by law.

EMERGENCY CONTACT & AUTHORIZED INDIVIDUALS

I authorize NAS to record and maintain the name(s) and phone number(s) of the emergency contact(s) and/or individual(s) with whom information may be shared in my medical record. I understand that it is my responsibility to notify NAS of any changes and to keep this information current. I agree to complete and maintain a HIPAA Emergency Contact Patient Consent Form.

COMMUNICATIONS & ADMINISTRATIVE AUTHORIZATION

I authorize NAS to:

- Leave phone messages regarding appointments, billing, or payment matters.
- Send correspondence to the address provided for the insurance holder unless alternative arrangements are made in advance.
- Communicate with me via phone calls, text messages, and/or email regarding appointments, reminders, and important practice notifications.

I consent to the release of medical information about me (and any individual for whom I am legally authorized to consent) to my health plan and to health care providers involved in my care, as reasonably necessary for treatment, payment, and health care operations.

I acknowledge that I have the right to request a **chaperone** for today's visit or any future visit. I acknowledge that I have been offered or have received a copy of the **Notice of Privacy Practices**.

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ELECTRONIC COMMUNICATION & PATIENT PORTAL

NAS offers secure electronic tools to support patient engagement and communication. These include:

- The **Patient Portal**, accessible via our website at **www.nephrologysyracuse.com**
- The **Healow Mobile App**, available for download on smartphones

Through these tools, I may send non-urgent messages, request prescription refills, view reviewed laboratory results, request appointment changes, make online payments, and more. I understand that these tools are secure and are an alternative to phone-based communication.

APPOINTMENT REMINDERS, CANCELLATIONS & NO-SHOW POLICY

NAS provides appointment reminders via text, email, or phone call.

If I am unable to attend a scheduled appointment, I agree to notify NAS **at least 24 hours in advance** to reschedule. Acceptable methods of contact include responding to reminder notifications or calling the office during business hours (Monday–Friday, 8:00 a.m. – 4:00 p.m.).

Appointments cancelled with less than 24 hours' notice or missed without notice (unless due to inclement weather or medical emergency) will result in **a $100 No-Show Fee**, which is not covered by insurance and may be required prior to scheduling future visits. This policy allows us to offer timely care to other patients in need.

Repeated no-shows or late cancellations may result in dismissal from the practice.

I understand that maintaining scheduled appointments is necessary to ensure continuity of care and that all active patients must have a future appointment on file.

PATIENT CONSENT FOR TELEMEDICINE, AMBIENT ARTIFICIAL INTELLIGENCE & SCRIBE SERVICES

As permitted by federal and state law, **telemedicine services** may be offered as an option for my care. Telemedicine involves the use of electronic communication technologies to provide health care services when I am not physically present with the provider.

I hereby consent to receive health care services via telemedicine. I understand that privacy and confidentiality laws apply to telemedicine and that my insurance carrier may access my medical records for quality review or audit purposes. I understand that I am responsible for any applicable copayments or coinsurance related to telemedicine visits.

I understand that I may withhold or withdraw my consent for telemedicine services at any time without affecting my right to future care. I may revoke consent verbally or in writing by contacting NAS at **(315) 478-3311**. Unless revoked, this consent remains valid without the need for additional signatures.

I understand that NAS providers may utilize **HIPAA-compliant ambient, artificial intelligence and/or medical scribe services**, including secure virtual scribing technology, to assist with documentation of patient encounters. All data is encrypted and maintained in compliance with federal and state regulations.

FINANCIAL CONSENT & PATIENT RESPONSIBILITIES

Thank you for choosing **Nephrology Associates of Syracuse, PC (NAS)** as your health care provider. As a patient, I understand and agree to the following responsibilities:

1. I am responsible for all charges not covered by my insurance, including copayments, coinsurance, and deductibles.
2. I am responsible for understanding my insurance benefits and coverage limitations.
3. I agree to provide accurate and current insurance information at each visit.

If I fail to provide valid insurance information at the time of service, I agree to be billed as a **self-pay patient**.

I agree to notify NAS **within 15 days** of any new or additional insurance coverage, including Medicaid, Medicare, Medicare Advantage, or supplemental policies. Failure to provide timely notification may result in self-pay responsibility for charges incurred.

Payment is expected at the time of service. If full payment is not possible, a partial payment is required. Payment plans may be arranged by contacting the NAS Billing Office at **(315) 362-5287**, Monday–Friday, 9:00 a.m. – 3:00 p.m. EST.

INSURANCE & PAYMENT POLICIES

It is my responsibility to verify whether NAS participates with my insurance plan. Participation varies by plan, even within the same insurance carrier. A list of participating insurance plans is available at **www.nephrologysyracuse.com**.

I understand that:

- My insurance card(s) must be presented at each visit
- Copayments are due at the time of service
- NAS accepts cash, checks, money orders, and credit cards

Any balances not covered by insurance are my responsibility.

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ASSIGNMENT OF BENEFITS

I authorize NAS to release all information necessary to process insurance claims and to receive payment directly from my insurance carrier. I authorize NAS to place my signature on file with the Upstate Medicare Claims Division for Medicare billing purposes.

This assignment remains in effect until revoked by me in writing. A photocopy of this authorization is considered as valid as the original.

I accept full financial responsibility for all services not covered by insurance, including reasonable collection costs and attorney fees if applicable. I understand that submission of an insurance claim does not guarantee payment.

ACKNOWLEDGMENT

I certify that I have read, understand, and agree to the contents of this document.

Date: _____

Signature of Patient or Legal Guardian: _____