NJ 08037, Hammonton

Advanced Kidney Care & Hypertension of South Jersey LLC

Arun Chawla, MD

CONSENT FOR TREATMENT FORM

Patient Name: ✕ _____ Date of Birth: _____

Consent for treatment: Knowing that I or the patient on the top of this form suffer from a condition requiring treatment, I voluntarily consent to such care. I consent to routine diagnostic procedures, x-rays and to medical treatment by physicians in Advanced Kidney Care & Hypertension of SJ (hereafter known as AKC) and other health care providers who might be called upon to consult or assist in my care as judged necessary by my treating physician. 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 a result of my care, treatment, or examination at AKC. Patients at AKC will be treated regardless of race, color, age, national origin, disability or religion.

Signature of the patient: ✕ _____ Date: _____

(Representative signature if patient is a minor or unable to consent)
Representative relation to Patient: _____ Witness: _____ Patient is unable to consent because: _____ Acknowledge of Privacy Practice: I understand and have been provided with AKC Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. AKC reserves the right to make changes to their Privacy Notice. Revised copies are available at all patient registration areas. By signing this form, I acknowledge that I have been afforded the opportunity to consider AKC Notice of Privacy Practices prior to signing of this consent and making of healthcare decisions.

Signature of the patient (or representative): ✕ _____ Date: _____

General Terms and Conditions:

- I understand that as a part of my healthcare, AKC originates and maintains health records describing my health history, diagnoses, symptoms, examinations, test results, treatment, and any plans for future care. This information is used as described in the Notice of Privacy Practices to plan my care and treatment, communicate with professionals involved in my care, apply my diagnostic and procedural information to my bill, verify third party payers, the services provided and routine operations such as audit reporting requirements, utilization review, and quality assessment activities.
- I am aware and have been advised that I or the patient suffering from a condition requiring treatment and I am presenting myself for treatment voluntarily consenting to such care. I consent to diagnostic procedures and medical treatment by physicians at AKC, its medical staff, and other affiliates and health care professionals who may be called upon to consult or assist in my care as is necessary. In their professional judgment, 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 a result of my care, treatment, or examination in AKC.
- AKC maintains patient medical records in paper, and electronic media, which may accessible to any physician or health care provider participating in my current or future care. I understand that these records will contain information about my diagnoses and treatment and may or may not contain information pertaining to psychiatric, alcohol, or drug abuse and HIV counselling or testing. Medical records are disclosed according to applicable New Jersey State Laws, federal laws 42 & 45 C.F.R. and the provision of this consent.
- I hereby assign to AKC physicians participation in my care and other licensed providers any and all rights and benefits to which I may be entitled arising out of any health care or liability insurance. I hold AKC harmless for any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: notification, pre-certification, prior or retrospective authorization, or utilization review of medical services I receive. I agree that I am financially responsible for deductibles, coinsurance, and uncovered services of my insurance policy.
- I agree to pay AKC the full and final amount of any and all bills rendered from the named patient, or me, which are not covered by my insurance. I authorize AKC to utilize the appeals process with my insurance carrier on my behalf for any denied service.
- I certify that the information given by me in applying for payment under titles XVIII and XVIX of the Social Security Act is correct. As acceptable I certify that I have received the Important Message from Medicare.

By signing this consent, I am indicating that I understand the contents of this document and agree to its provisions including the disclosure of information in accordance with AKC Notice of Privacy Practices. I am signing this consent voluntarily.

Signature of the patient (or representative): × _____ Relationship: _____ Date: _____

NJ 08037, Hammonton

Phone: (609)535-3435

Advanced Kidney Care & Hypertension of South Jersey LLC

Arun Chawla, MD

NOTICE OF HIPAA PRIVACY PRACTICES

Effective April 14, 2003 the Federal Government has passed legislation requiring all medical facilities to safeguard the privacy of our patient's personal medical information. The legislation is called the Health Insurance Portability and Accountability Act (HIPAA).

This means we will not disclose your health information without your written authorization. We are permitted by this law to release information to assist a physician/facility in providing your care.

We require your written consent to disclose your health information in the following situations:

- We may be required by your insurance carrier to submit our chart note relating to a visit in order for them to process the claim.
- We will not discuss your medical care or a bill pertaining to your care with anyone but you. If you wish to authorize us to discuss your care with a spouse or family member, please indicate below. I authorize Advanced Kidney Care & Hypertension of SJ, to discuss my medical care with:

Name (print): _____ Relationship:

_____ Date of birth of authorized person (for identifying purposes): _____ Phone number of authorized person (for identifying purposes): _____

This form must be signed on order for a medical staff member of Advanced Kidney Care & Hypertension of SJ to discuss your lab/test results with you over the phone.

Patient Name: _____

Patient Signature: X_____

Witness: _____

Date: _____