CONSENT FOR GENERAL PATIENT CARE

I hereby authorize employees and agents; including physicians of Advanced Kidney Care to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient, Parent or Legal Guardian **Date**

Please print name (if different from patient named below)_____

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to Advanced Kidney Care of North Texas (AKCNT) and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to AKCNT. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of AKCNT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Signature of Patient, Parent, or Legal Guardian **Date**

Patient Name_____DOB_____