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# Assignment of Benefits/ Payment of Signature Kidney Care PLLC medical bills:

**Name:** _____ **Date of Birth:** _____

I assign the benefits payable for physician services to Signature Kidney Care PLLC.
I request that bills from Signature Kidney Care PLLC, are paid on my behalf by the "third-party payer" e.g., medical insurance companies, including Medicare and Medicaid,

I agree to pay Signature Kidney Care PLLC for all charges not covered by any third-party payer**. I agree that there will be a $20 administrative fee for insufficient funds.**

**RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES:**
I understand I must sign an authorization to release any information about the medical treatment I receive, for a third-party payer to pay for any or all my bills related to all visits to Signature Kidney Care. Therefore, I am allowing Signature Kidney Care PLLC to release any information to the "third-party payer" needed to determine payments related to my medical treatment.

**I understand I have the right to withdraw this consent, in writing, at any time except where Signature Kidney Care PLLC has already made a disclosure based on my past consent.**

**This consent will remain in place unless withdrawn in writing.**

Signature of Patient: _____

Print Name: _____ Date: _____

Signature of guardian if patient is unable to sign: _____

Print Name: _____ Date: _____

Relationship to patient: _____