KIDNEY CARE

www.SignatureKidneyCare.net
2001 North MacArthur Blvd Suite 335
Irving, TX. 75061

Tel: (214) 716 – 7573 **Fax: (888) 657 - 4737**

CONSENT FOR TREATMENT

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

TO OUR PATIENTS: Before you begin treatment at Signature Kidney Care PLLC, the law requires we explain your rights and responsibilities. If you have a complaint or concern about your care, please talk to your doctor or provider.

Please read and sign this form. If you are having trouble understanding any of this information, please ask us for help.

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to treat me. I understand this could include lab tests, x-rays, education or other diagnostic procedures. I understand my provider is available to explain my treatment, and that I have the right to refuse treatment.

PATIENT RIGHT TO PRIVACY: I acknowledge I have been told about Signature Kidney Care PLLC's privacy practices and HIPAA regulations, listed on a separate form. I have been offered a copy of Signature Kidney Care PLLC notice of privacy practices to keep for myself.

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 This consent will remain in place unless withdrawn in writing.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 X_____
Print Name: _____ Date: _____

Signature of guardian if the patient is unable to sign X _____
Print Name: _____ Date: _____
Relationship to patient: _____