ALTITUDE KIDNEY HEALTH, PLLC

PATIENT CONSENT TO RECEIVE MEDICAL CARE

The purpose of this form is provide written authorization of my consent to receive health care services.

1) **Consent for rendering medical care.** I voluntarily give my consent to Altitude Kidney Health, its providers, staff and affiliates (hereafter “the Clinic”), to render health care typical to outpatient services including history taking, diagnostic procedures including labs and radiology imaging, medications both oral and injectable, both in-person and via alternative means such as telehealth (for example, “video visits.”). I understand that the Clinic and its designees will provide care to the best of their ability, and that despite this, medical care is not an exact science and therefore no guarantees are made regarding treatment or services and their outcomes in the Clinic.
2) **Financial agreement.** I understand that this agreement is a contract which obligates me to pay all charges for my treatment, whether through insurance company (whether private, nonprofit or governmental such as Medicaid or Medicare) reimbursement for services, out-of-pocket payments, or a combination of both. I understand that the Clinic has predetermined charges consistent with area norms and the services it provides. I acknowledge that it frequently is not possible to predetermine which exact services are indicated and their specific cost as the Clinic is acting in good faith to offer the best medical care possible, and certain costs are either unpredictable or unknown. I am aware that I have a right to request a non-binding estimate of charges for the services to be rendered.
3) **Specimen handling.** I understand that specimens as a byproduct of my care may be produced and will be retained, managed and disposed of by the Clinic in accordance with law.
4) **Financial assistance.** If I cannot pay my bill, I understand that I may be able to inquire about and qualify for financial assistance.
5) **Nonpayment.** I understand that, after a good faith effort to notify in compliance with law, the Clinic may employ third party services for the collection of delinquent debts due to my nonpayment for services rendered.
6) **Communication consent.** I understand that by providing my telephone number and or email, I give my consent to the Clinic and its assigns to receive communications for the purposes of scheduling, follow-up, and or payment of bills.
7) **Preauthorization.** I understand it is my duty to obtain preauthorization for services where required by my insurance coverage plan.
8) **Assignment for payment.** I authorize and direct payment for health care services be paid on my behalf to the Clinic.
9) **__________(initials) Acknowledgement of privacy practices.** I acknowledge that the Clinic has provided me a copy of its Notice of privacy practices which is also available on its website, www.altkidney.com, and that this does not affect the care I receive at the Clinic.

I acknowledge that I have read this document, I understand its contents, and I have access to a copy for my records. I am the patient or authorized person to sign this consent.

My signature is my consent to the above terms:

Signature:____ **Date**:________
Patient/parent/legal guardian (or person authorized to give consent)

Name of patient: ____

If signed by person other than patient, provide:

Name	Relationship to patient	ID/driver’s license number:
Witness name:	Witness signature	Date