Texas Institute for KIDNEY AND ENDOCRINE DISORDERS

PATIENT CONSENT FOR THE DISCLOSURE OF INFORMATION (HIPPA)

I have had the opportunity to review the Notice of Privacy Practices and have had any questions answered by the office. I understand that by signing this form I consent to the following:

A. **Sharing information for the purposes for treatment:** You will share my information with all my treatment team, both within this office and with other providers (Personal & Institutional) to provide me with quality care and the educational/wellness programs specified in my insurance plan.

B. **Sharing of information for purposes of payment:** You will share all necessary information with my insure (s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the bill process (including, but not limited to claims representatives, data warehouses, billing companies).

C. **Sharing information for purposes of operations:** You will share all information necessary for ongoing operations of this office, including, but not limited to the credentialing processes, per review, accreditation and compliance with all federal and state laws.

D. **I have agreed to the rule of paying $35.00 for a NO SHOW appointment,** if I have not cancelled the appointment **24 hours prior** to that appointment.

E. **I have agreed to the rule of paying $35.00** for any **NSF** (non-sufficient funds) **fee** for any checks that do not clear. The amount of the transaction and NSF fee must be **paid in full** via cash, money order, or credit card before patient can be seen.

Name:_____ Date of Birth:_____

Authorized person or persons that may have access to my medical information:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

Signature: _____ Date: _____

If patient is a Minor, Relationship to Patient _____