DIALYSIS ACCESS CENTER, INC.
CONSENT FOR OUTPATIENT SERVICES

1. NURSING CARE:

Dialysis Access Center, Inc. provides only general nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. Dialysis Access Center, Inc. shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

2. CONSENT TO MEDICAL AND SURGICAL PROCEDURES:

The undersigned consents to the procedures that may be performed on an outpatient basis, including emergency treatment or services, which may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or services rendered the patient under the general and special instructions of the patient's physician or surgeon. In the Dialysis Access Center, Inc., teaching programs are conducted under supervision. The undersigned consents to the admittance of approved observers to the procedure room. The undersigned agrees that unless the Dialysis Access Center, Inc. is notified in writing, the undersigned consents to participate as a teaching subject in Dialysis Access Center, Inc.'s education programs and to treatment by persons involved in the education programs.

3. LEGAL RELATIONSHIP BETWEEN DIALYSIS ACCESS CENTER, INC. AND PHYSICIANS:

Under applicable law, physicians are required to disclose to their patients when they have a financial interest in an organization to which they refer patients. Please be advised that the physicians in this medical practice may have a financial interest in Dialysis Access Center, Inc., a California Professional Medical Corporation, to which you are being referred for medical services. Potential sources of information concerning alternatives can either be obtained from the Yellow Pages or the County Medical Association. We would be happy to discuss these alternatives with you. You are always free to choose any organization you wish for obtaining the services that we order or request for you.

4. RELEASE OF INFORMATION:

Dialysis Access Center, Inc. may disclose all or any part of the patient's record to any person or corporation which is, or may be, liable under a contract to Dialysis Access Center, Inc. or to the patient or to a family member or employer of the patient, for all or part of the Dialysis Access Center, Inc.'s charges.

5. PERSONAL VALUABLES:

It is understood and agreed that Dialysis Access Center, Inc. requests that patients leave all valuables at home or with family members and Dialysis Access Center, Inc. shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs or other articles of unusual value.

6. ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign to Dialysis Access Center, Inc. and the authorized providers of care therein, any and all insurance benefit to become due me to the full extent of my financial obligation. I understand that I am not relieved of responsibility for Dialysis Access Center, Inc. charges incurred by these outpatient services, except as to the amount actually received by Dialysis Access Center, Inc.

7. FINANCIAL AGREEMENT:

In consideration of the services to be rendered to the patient, the undersigned, whether signing as patient or as agent of the patient, agrees to pay all charges made against the patient by the Dialysis Access Center, Inc. and authorized providers of care therein, and in the event the account is referred to any attorney or agency for collection, agrees to pay reasonable attorney's fees and collection expenses. Dialysis Access Center, Inc. reserves the right to require proof of patient's ability to pay the Dialysis Access Center, Inc. account and may require payment of a deposit prior to performing your outpatient procedure(s). Any deposits paid shall be applied to secure payment of the total bill owed. If the patient is insured by a Health Maintenance Organization (HMO) or PPO Benefit Plans, the patient acknowledges and agrees to bear full financial responsibility for all services provided as listed below if:

- The services are not covered under your HMO or PPO Benefit Plan(s), or;
- The services have not been otherwise approved for payment by your HMO or PPO Benefit Plan(s).

8. MEDICARE PATIENT'S CERTIFICATION:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release to the Center for Medicare and Medicaid Services or its intermediaries any information needed for this or a related Medicare claim and request that payment of authorized benefits be made on my behalf.

PLEASE READ AND RESPOND TO THE STATEMENT REGARDING PATIENT RIGHTS, NOTICE OF PRIVACY PRACTICES.

I have received information about "Your Right to Make Decisions About Medical Treatment" and "Patients' Rights": □ Yes □ No

I have received the "Notice of Privacy Practices": □ Yes □ No

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date:_____ Time:_____ a.m./p.m.

Signature:_____
(patient/parent/conservator/guardian)

If signed by other than patient, indicate relationship:_____

Witness signature:_____

PERSON TRANSLATING IF TRANSLATION IS REQUIRED:

_____ _____

Name of Translator **Relationship**

Inability to Obtain Acknowledgement of "Notice of Privacy Practices":

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained:

- ☐ Patient lacks the capacity to understand the Privacy Notice.
- ☐ Patient is on an Involuntary Commitment.
- ☐ Patient's medical condition prohibits acknowledgement at this time.
- ☐ Other: _____

_____

Signature of Dialysis Access Center, Inc. Representative: _____

Date: _____