AUTHORIZATION / ASSIGNMENT OF BENEFITS STATEMENT / NOTICE AND ACKNOWLEDGEMENT

Patient Name_____

Social Security #_____

I authorize the physicians of *EAST BAY NEPHROLOGY MEDICAL GROUP, INC. (EBNMG)* to treat me. I also request that my insurance carrier make payment of authorized Medicare or other Insurance benefits on my behalf to EAST BAY NEPHROLOGY MEDICAL GROUP, INC., for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or my insurance company and its agents any information needed to determine benefits payable.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that I am financially responsible for any charges not covered by insurance benefits. In Medicare assigned cases, *EAST BAY NEPHROLOGY MEDICAL GROUP, INC.* agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

I acknowledge that I have received East Bay Nephrology's attached Notice of Privacy Practices.

A Photostat of this authorization shall be as valid as the original.

Patient or Personal Representative Signature **(Date)**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

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Revised 4/2003
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