

**BAY AREA RENAL STONE CENTER
ASSIGNMENT OF BENEFITS**

This assignment of benefits allows **BAY AREA RENAL STONE CENTER** (Center) to be paid directly by my health insurance carrier or other benefit plan for the services provided to me, my minor child, or other person entitled to health care benefits for this date of service. In return for services rendered and to be rendered by Center, I hereby irrevocably assign and transfer to the Center, title and interest in all benefits payable for the health care rendered, which are provided in any and all insurances policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the Center the right to recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the Center to pursue any such right or recovery. In no event will the Center retain benefits in excess of the amount owed to the Center for the care and treatment rendered during this date of service. I have read and been given the opportunity to ask questions about this document freely and without inducement, other than the rendition of services by the Center.

Initials _____

FINANCIAL AGREEMENT

I, the undersigned, agree, whether I sign as parent, guardian, spouse, agent, guarantor, or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the Center in accordance with the regular rates and terms of the Center. Should the account be referred to an attorney or collection agency for collection, I shall pay actual attorney's fees and collection expenses.

Initials _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Bay Area Renal Stone Center's (Center) notice of privacy practices that describes how my health information is used and shared. I understand that the Center has the right to change this notice at any time. I may obtain a current copy by contacting the Center or by visiting the Web site at www.BARSC.com.

Initials _____

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR FRIENDS**

I acknowledge my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others responsible for my care or designated by me. I authorize the use or disclosure of the below named individual's protected health information to the following person(s):

Name – Please Print

Relationship

Patient/Patient Representative

If Patient Representative, print name and relationship Date

Spouse

BARSC Representative Signature