RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY
DECON (Diabetes & Endocrine Center of Nevada)

Name of Patient: _____ Date of Birth: _____

I hereby authorize Nitesh D Kuhadiya, MD, MPH, PLLC DBA DECON (Diabetes & Endocrine Center of Nevada) to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

a. Any person or entity responsible for payment for the medical services rendered to me at the Facility, including third party payors, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, in connection with obtaining payment for the medical services rendered to me at the Hospital by employees of the Facility or any person providing services at the Facility.
b. Federal, State or other governmental or quasi-governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.
c. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the Facility and/or its physicians.
d. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.
e. To persons authorized by the Facility in connection with the performance of supervised research in compliance with the rules and procedures of the Facility. I also understand that an authorized researcher may contact me at some future date.

I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received.

This includes information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS).

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to DECON separately from other Facility or professional bills. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

FINANCIAL RESPONSIBILITY: In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, I guarantee and agree to pay charges for those services rendered including any amount not paid in my insurance plan, Medicare, health service plan or health maintenance organization. Members of health maintenance organizations (and preferred provider organizations) are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirements for primary referral, emergency admission, pre-certification and utilization review. These are conditions to payment of benefits by the health maintenance organizations (and preferred provider organizations). DECON, may not participate with your health care coverage plan and the charges may not be covered.
By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason.

HEALTH INFORMATION PRIVACY PROTECTION ACT (HIPPA): I acknowledge that I have received a copy of DECON Notice of Privacy Practice.

A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

_____ _____
(Signature of patient, parent or legal guardian of patient) (Date signed)

_____ _____
(Witness) (Date signed)

I AUTHORIZE _____/_____ ACCESS TO MY MEDICAL RECORDS/
Name relation

ACCOUNT ON MY BEHALF