Kidney Specialists of New Mexico, P.C.
717 Encino Place NE, Suite 26
Albuquerque, NM 87102
Phone: (505) 884-4545 Fax: (505) 884-4114

PATIENT BILLING POLICY

1. You need to be familiar with your health insurance policy and what it covers PRIOR to being seen by our providers. You also need to be familiar with participating providers for your plan, including laboratories, x-ray facilities and hospitals. We will bill your insurance company if the provider whom you see participates with your insurance plan.
2. **Patients must bring their current insurance identification card each time they are seen.**
3. If your insurance company requires a referral to be seen at our office, it is YOUR responsibility to obtain a referral from your primary care provider and bring it with you to your appointment. If your insurance requires a referral and you do not bring it, you will not be seen.
4. Please be prepared to pay any co-payment, deductible and/or co-insurance as required by your insurance company at the time you are seen. We accept cash, personal checks, VISA and Mastercard as payment.
5. Patient balances must be paid in full within 30 days of the date of service. Please be advised that as of July 1, 2014, there will be a rebilling fee of $5.00 PER MONTH for any patient balance that is over 90 days old.
6. Our practice charges $45.00 for any returned check. We will only accept cash, VISA or Mastercard as payment for a returned check and for future services should your check be returned to our office.
7. If you have any concerns as to how much your out-of-pocket is estimated to be for services rendered by our office, please contact our office prior to the date of service so that we may contact your insurance company for you, before you are seen.
8. If you "no-show" for an appointment or cancel an appointment with less than 24 hours notice more than once, you may be subject to a no-show fee and/or discharge from this practice.
9. I, _____(patient's name or legal guardian name) do give my permission to be contacted via cellular telephone, if necessary, regarding any issues with my account or billing to my insurance company.

Insurance Authorization and Assignment: I hereby authorize Kidney Specialists of New Mexico, P.C. to furnish information concerning my illness and treatment to any physician or hospital whose care I have been under, or whom I may be referred to for additional diagnosis and treatment, and to my insurance carrier to process claims for medical benefits for me and/or my dependents. I hereby assign to Kidney Specialists of New Mexico, P.C. all insurance payments for services rendered. A photocopy of this authorization may be honored. I consent to photocopy to be performed, if necessary, as visual data for my medical record and/or teaching purposes.

Patient Name (Print) _____

Signature _____ Date _____

IF YOU ARE UNDER THE MEDICARE PROGRAM, PLEASE READ AND SIGN THE STATEMENT BELOW: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kidney Specialists of New Mexico, P.C. for any services furnished to me by the providers in this office. I authorize any holder of medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services furnished me.

Patient Name (Print) _____

Signature _____ Date _____