Nephrology Associates of Tidewater

STATEMENT TO PERMIT PAYMENT OF MEDICARE/COMMERCIAL/MEDICAID BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

☐ **KEMPSVILLE**
6160 Kempsville Circle,
Suite 302A
Norfolk, VA 23502
Phone (757) 466-9288
FAX (757) 461-6642

☐ **MARYVIEW**
3640 High Street,
Suite 2G
Portsmouth, VA 23707
Phone (757) 977-1110
FAX (757) 977-1107

☐ **HARBOURVIEW**
5140 River Club Dr.
Suite 102
Suffolk, VA 23435
Phone (757) 977-1110
FAX (757) 977-1107

☐ **FORT NORFOLK**
301 Riverview Avenue
Suite 600
Norfolk, VA 23510
Phone (757) 627-7301
FAX (757) 627-6238

☐ **SUFFOLK**
2790 Godwin Boulevard,
Suite 255
Suffolk, VA 23434
Phone (757) 925-0637
FAX (757) 925-0412

☐ **VIRGINIA BEACH**
1800 Camelot Drive
Suite 401
Virginia Beach, VA 23454
Phone (757) 496-3706
FAX (757) 496-3715

☐ **CHESAPEAKE**
300 Medical Parkway,
Suite 222
Chesapeake, VA 23320
Phone (757) 436-5544
FAX (757) 436-7323

☐ **FRANKLIN**
1333 Armory Drive
Franklin, VA 23851
Phone (757) 562-2848
FAX (757) 925-0412

☐ **PRINCESS ANNE**
1975 Glenn Mitchell Drive
Suite 302A
Virginia Beach, VA 23456
Phone (757) 689-0211
FAX (757) 301-2595

☐ **EASTERN SHORE**
9550 Hospital Road
Nassawadox, VA 23413
Phone (757) 442-9080
FAX (757) 442-9082

BENEFICIARY'S (PATIENT'S) NAME _____

☐ I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Nephrology Associates of Tidewater, Ltd.,* for any services furnished to me by that physician/ provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

☐ I hereby assign, transfer and set over to *Nephrology Associates of Tidewater, Ltd.,* all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I further authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits for related services.

_____ _____
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) DATE

DEEMED CONSENT FORM

I understand that the laws of Virginia provide if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the then current guidelines of the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

_____ _____
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) DATE

_____
SIGNATURE OF WITNESS