Nephrology & Hypertension MEDICAL ASSOCIATES

RETURN 5 DAYS PRIOR TO SCHEDULED APPOINTMENT

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION **Referred By:**

Name:_____Soc Sec #:_____
First Mid Last

Address:_____
Street / PO Box City State Zip

Telephone: Home (_____) _____ Work (_____)_____Cell (_____)_____

Sex: M F Date of Birth: _____/_____/_____ E-Mail: _____
Email is required for our Patient Portal and other educational communications.

Primary Care Physician: _____
Name Phone Address

Marital Status: _____ Race:_____ Ethnicity: Hispanic_____ Non-Hispanic_____

Emergency Contact:_____
Name Phone Relationship to Patient

Spouse Info (*If Applicable*):_____
Name Date of Birth Phone Employer

EMPLOYMENT INFORMATION

Employed By_____Occupation_____

Business Address_____Business Telephone_____

Employment Status: FT_____ PT_____ Self____ Retired____ Military____ Not Employed_____ Student_____

PRIMARY INSURANCE ___Medicare ____Medicaid ____Self Pay _____Commercial

Insurance Company:_____
Name HMO / PPO / OPEN ACCESS

Policy #_____Group #_____Specialist Co-Pay_____

Address_____City _____State_____Zip_____

Name of Insured_____ Insured SS #_____

Relationship to Patient_____ Date of Birth of Insured_____

Patient Preference: _____
Hospital Laboratory Pharmacy/Address

SECONDARY INSURANCE _____Not Applicable ___Medicare ____Medicaid ____Self Pay _____Commercial

Insurance Company:_____
Name HMO / PPO / OPEN ACCESS

Policy #_____Group #_____Specialist Co-Pay_____

Address_____City _____State_____Zip_____

Name of Insured_____ Insured SS #_____

Relationship to Patient_____ Date of Birth of Insured_____

ASSIGNMENT AND RELEASE

Authorization to treat and release information to insurance carrier for direct payment to the provider: I authorize treatment and the release of any medical information (acquired in my treatment) to process claims to my insurance carrier. I authorize direct payment from my insurance company to my provider. At any time should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor listed above, which could include a 25% collection fee. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services. I authorize the release of medical records to Nephrology and Hypertension Medical Associates PC as necessary for continuity of care. Also, I understand that the practice will provide, at my request, a copy of the HIPAA Notice of Privacy, which is clearly posted in the lobby area.

_____ _____ _____
PATIENT'S SIGNATURE PRINT NAME DATE

_____ _____ _____
GUARANTOR'S SIGNATURE (If other than patient) PRINT NAME DATE