WELCOME TO NEPHROLOGY ASSOCIATES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

NAME _____ MALE_____ FEMALE_____

STREET ADDRESS_____

MAILING ADDRESS_____

CITY, STATE, ZIP_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE _____

MINOR_____ SINGLE_____ MARRIED_____ DIVORCED_____ WIDOWED_____ SEPARATED_____

EMAIL ADDRESS _____

ETHNICITY: ____Hispanic or Latino ____Not Hispanic or Latino ____Refused to Report/Unreported

RACE: ___White ___American Indian or Alaska Native ___Asian ____Black or African American
____Native Hawaiian

LANGUAGE PREFERANCE: ____English ____Spanish ____German

EMPLOYER_____

REFERRED BY_____ PRIMARY CARE PHYSICIAN_____

INDIVIDUAL RESPONSIBLE FOR PAYMENT OF BILL

NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____

CITY, STATE, ZIP_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

HOME PHONE_____ WORK PHONE_____

EMPLOYER_____

EMERGENCY CONTACTS

IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE CALL?

NAME_____

HOME PHONE_____ WORK PHONE_____

NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU:

NAME_____

HOME PHONE_____ WORK PHONE_____

I AUTHORIZE THIS OFFICE TO RELEASE INFORMATION TO MY INSURANCE COMPANY FOR THE PURPOSE OF PRECERTIFICATION, WORKERS COMP BENEFITS AND/OR PAYMENT OF CLAIMS.

PATIENT SIGNATURE (OR PARENT IF MINOR) DATE

INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARDS SO THAT THEY MAY BE COPIED FOR OUR FILES.

PRIMARY INSURANCE_____ SUBSCRIBER_____

SECONDARY INSURANCE_____ SUBSCRIBER_____

IS THIS A WORK RELATED INJURY? YES_____ NO_____

IS THIS RELATED TO AN AUTO ACCIDENT? YES_____ NO_____

ARE YOU WITHOUT INSURANCE AT THIS TIME?

FINANCIAL POLICY

WE WILL SUBMIT CLAIMS TO YOUR INSURANCE COMPANY IF THE COMPANY'S ADDRESS AND TELEPHONE NUMBER ARE PROVIDED TO US AT THE TIME OF SERVICE. WE DO REQUIRE 20% OF THE TOTAL FEE TO BE PAID AT THE TIME OF YOUR VISIT UNLESS WE ARE PARTICIPATING WITH YOUR INSURANCE COMPANY OR YOUR POLICY ONLY REQUIRES A COPAY. THE COPAY IS DUE AT THE TIME OF SERVICE.

MANAGED CARE PATIENTS ARE RESPONSIBLE TO MAKE SURE ALL NECESSARY REFERRALS HAVE BEEN DONE BY THEIR PRIMARY CARE PHYSICIAN BEFORE SERVICES ARE PERFOMED, AS THE PATIENT BECOMES FULLY FINANCIALLY RESPONSIBLE FOR ALL SERVICES WITHOUT REFERRALS.

PLEASE LET US KNOW IF YOUR POLICY REQUIRES A PREAUTHORIZATION FOR SURGERY. WE WILL BE HAPPY TO CALL YOUR INSURANCE COMPANY, PROVIDED WE ARE FURNISHED WITH A TELEPHONE NUMBER.

PAYMENT AUTHORIZATION

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE OFFICE UNLESS PAYMENT IS MADE AT THE TIME OF SERVICE.

PATIENT SIGNATURE (OR PARENT IF MINOR) DATE

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY. THE INFORMATION YOU HAVE PROVIDED WILL HELP US MEET YOUR HEALTHCARE NEEDS MORE EFFECTIVELY. IF AT ANY TIME YOU HAVE ANY QUESTIONS, PLEASE ASK – WE'RE ALWAYS HAPPY TO HELP.