

# 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 \_\_\_\_\_

MINOR \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED \_\_\_\_\_ SEPARATED \_\_\_\_\_

EMPLOYMENT STATUS \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

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.

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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 PERFORMED, 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.

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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.