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REGISTRATION FORM

Date: _____________

For office use only: Chart#: ________

PATIENT INFORMATION:

Patient Name: ______________________________ DOB: ___________ SS#: _____________

Last Name First Name Middle Initial MM/DD/YYYY

Address: ___________________________________City __________________ Zip ____________

Phone (H): ______________________Phone (W):_______________ Phone (C): __________________

Emergency Contact: ____________________ Relationship: ____________ Contact #: ______________

Gender: M ___ F ___ Marital Status: __________ Preferred Language: (Besides English)_____________

Occupation: _______________ Employer/Address: ____

DEMOGRAPHIC:

Ethnicity: __ Non-Hispanic __ Hispanic __ Not Specified

Race: __ African or African American __ Asian or Asian American

__ Caucasian or European American __ Native American or Native Alaskan

__ Native Hawaiian or Pacific Islander __ Other

INSURANCE INFORMATION: (Please present insurance cards and an identification card to receptionist)

Primary Insurance Co: _________________ Group #: __________ Policy ID#: _____________

Name of Insured: _____________ Effective Date: ___________

Secondary Insurance Co: ________________ Group #: __________ Policy ID#:_____________

Name of Insured: _____________ Effective Date: ___________

(Please note that if you have a secondary insurance and it is not identified the patient will be financially responsible for any claims not paid.)

REFERRAL INFORMATION: (If applicable)

What is the reason for your visit? ______________________________ **Referring Physician:** ____________________

Name & Phone Number of Primary Care Physician: ____

Name & Phone Numbers of Other Specialists: ____

Lab Test(s): __________________________ **Date/Location:** ______________________

Imaging/Scans: ______________________ **Date/Location:** ______________________

Other Tests: _________________________ **Date/Location:** _____________________

Name: __________________ Date: ____________________

NOTE: This is a confidential record of your medical history. As your doctor, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Are you allergic to any food, medicine or environmental factors? ___Yes ___ No

If yes, please write down allergies: ____

Are you pregnant? ___Yes ___ No ___ N/A

Are you breastfeeding? ___ Yes ___ No ___ N/A

Do you have any special needs? ___ Yes ___ No

If yes, please describe: ____

Are we allowed to draw blood on either arm? ___ Yes ___No

If no, which arm can we draw blood from? ___ Left ___Right

Past Medical History: Check all that apply					
	Anemia		Hearing Problems		Migraine
	Arthritis /Joint Disease		Heart Disease/Heart Failure		Muscular Disease
	Asthma/Emphysema /COPD		High Blood Pressure		Prostate Problems
	Anxiety/Depression/Psych. Disorder		High Cholesterol		Seizure Disorder/Stroke
	Bone Disease		Immune System Disorder		Sexually Transmitted Disease
	Cancer: (Type)		Irregular Heart Beat		Thyroid Dysfunction
	Diabetes / High Blood Sugar		Kidney Problems/Stones		Urinary Tract Disorders
	Fracture(s)		Liver Problems		Vascular Disease
	Gastrointestinal Problems		Lupus		Vision Problems
Other:					

For Internal Medicine Patients Only:	
Date of Last Colonoscopy:	Date of Influenza Vaccine:
Date of Last Mammogram:	Date of Pneumonia Vaccine:
Date of Last Pap Smear:	Please provide us a copy of immunization record.
Date of Last Prostate Exam:	

Surgical History: Please write the name of procedure and date

Medications/Supplements	Dose	Frequency

Pharmacy Name , Location and Phone#:	

Social History:	Yes	No	Frequency
Do you currently use TOBACCO?			Packs per day
Do you drink ALCOHOL?			
Do you use any ILLICIT DRUGS?			

Family History:	Yes	No	Relationship
Cancer? Type			
Heart Disease?			
Diabetes?			
Obesity?			
Kidney Disease?			
Other:			

CENTER FOR NEPHROLOGY AND HYPERTENSION

CONSENT FORMS (Please read and sign by the "X")

A) CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATION:

I understand that as part of my healthcare, Center for Nephrology & Hypertension originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves:

- As a basis for planning your care and treatment;
- As a means of communication among the many health professionals who contribute to your care;
- As a source for applying your diagnosis and procedure/surgical information to my bill;
- As a means by which a third party payer can verify that services billed were actually provided;
- As a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a copy of Notice of Privacy and Information Practices, which provides a more complete description of information uses and disclosures, I understand that we have the right to change the notice and practices, and prior to implementation will mail a copy of any revised notice to the address I have provided. I also understand that I have the right:

- To object to the use of my health information for directory purposes;
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, but that Center for Nephrology & Hypertension is not required to agree to the restrictions requested;
- To revoke this consent in writing at any time, except to the extent that the organization has already taken action in reliance thereof.
- By signing below, I affirm that I have received the HIPAA Notice of Privacy Practices

✖________________________________ ____________________

Patient or Authorized Representative Date

B) FINANCIAL POLICY:

Thank you for choosing for Center for Nephrology & Hypertension for your healthcare needs. This financial policy is an important part of your healthcare. Due to increased insurance company demands, we ask you to read and agree to the following policies.

- I request Center for Nephrology & Hypertension to bill my insurance company on my behalf. Center for Nephrology & Hypertension will agree to invoice my insurance company in a timely manner as long as the information provided is correct and accurate.
- I understand that it is my responsibility to know my healthcare policy and to verify all benefits and coverage information prior to having any services rendered.
- I understand that it is my responsibility to notify Center for Nephrology & Hypertension of any changes to my insurance plan or policy prior to my visit.
- I agree to pay my co-pay, coinsurance, deductible or any uncovered services that my insurance company deems "patient responsibility" AT TIME OF SERVICE. Center for Nephrology & Hypertension accepts most major credit cards, debit cards, checks, and cash.
- I understand that I must pay any outstanding patient balance prior to being able to schedule future appointments.
- I agree to pay in a timely manner. If Center for Nephrology & Hypertension needs to send me more than one statement, I understand a $10 processing fee may be assessed for each subsequently-mailed statement. If, after three statements are mailed, and I do not pay my balance in full or agree to a payment plan, Center for Nephrology & Hypertension reserves the right to send me to collections.
- I understand I may be personally responsible for payment if:
  - I cannot verify that I have insurance at the time of my appointment.
  - I do not have active insurance coverage (please ask about our "Cash Pay" policy.)
  - My insurance is not accepted by Center for Nephrology & Hypertension.
  - I receive a service that is not covered by my policy.
  - My insurance company denies my claim for any reason that is not resolvable.

✖________________________________ ____________________

Patient or Authorized Representative Date

C) AUTHORIZATION FOR RELEASE OF INFORMATION BY CENTER FOR NEPHROLOGY & HYPERTENSION:

I hereby authorize and direct Center for Nephrology & Hypertension, having treated me, to release to governmental agencies, insurance carriers, or others who permit representatives thereof to examine and make copies of all records relating to such care and treatment.

✖________________________________ ____________________

Patient or Authorized Representative Date

D) ASSIGNMENT OF BENEFITS TO CENTER FOR NEPHROLOGY & HYPERTENSION:

I hereby assign, transfer and set over to Center for Nephrology & Hypertension, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization, physician services and medical care to cover the cost of the care and treatment rendered to myself or my dependents by Center for Nephrology & Hypertension. If no payment is received within ninety days, we have the right to turn your account over to a collection agency. All legal costs incurred will be your responsibility.

✖________________________________ ____________________

Patient or Authorized Representative Date