Permian Nephrology Associates

COMPLETE ENTIRELY, DO NOT LEAVE ANY BLACK SPACES

Last Name: First Name: MI:

Social Security #: Date of Birth:

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address: City: State: Zip Code:

Home Phone: Cell Phone: Work/Other Phone

Email Address:

Spouse's Name: Phone Number:

Emergency Contact: Relation: Phone Number:

Preferred Pharmacy: Preferred Lab:

Preferred Language: Race: Ethnicity:

Primary Care Physician:

Any Other Physicians You Want Our Records Sent To:

Guarantor Information (Person Responsible For Payment), if different from above:

Guarantor Name: Relationship:

Social Security #: Date of Birth:

Insurance Information

Primary Insurance: Group: Policy:

Secondary Insurance: Group: Policy:

Tertiary Insurance: Group: Policy:

FINANCIAL AND MANAGED CARE POLICY STATEMENT

The patient / responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing your doctor.

1. Patients with an insurance co-payment are expected to make payment when checking in for their appointment.
2. Patients with insurance are expected to pay any personal balance that is due immediately after their insurance company(s) remit payment. If insurance does not remit payment within 45 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to us immediately.
3. Not all services are covered benefits of all insurance plans. The patient / responsible party maintains the responsibility of obtaining authorizations and verification of applicable coverage.
4. The patient is responsible for payment of any unpaid deductibles, co-insurance, or other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full or make payment arrangements at the time of service.
5. Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications, or other forms required by your insurance company to process payment for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.
6. We do not bill third parties in legal situations or injuries (non-work related). We bill your health insurance. Any balance unpaid by your health insurance will be billed to the guarantor on the patient account.

We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover, American Express). Returned checks and balances older than 45 days may be subject to additional collection fees. We encourage you to communicate with our billing staff any temporary financial problems may affect timely payment so that we can assist you in the management of your account. Our staff will assist you with any billing questions or issues before or after today's appointment. Thank you for your understanding and cooperation with this policy.

1. I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.
2. I agree that this authorization is valid regardless of when I receive services at this office, that the information on pages above is accurate, and that I am the patient or authorized to sign this document.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Midland Kidney Care, PLLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Midland Kidney Care, PLLC to:

1. Release any information necessary to insurance carriers regarding my illness and treatments.
2. Process insurance claims generated in the course of examination and treatment.
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

Patient/Responsible Party Signature: _____ Date: _____

Printed Name: _____

Acknowledgement of Receipt of Patient Rights and Responsibilities

I have been made aware of my rights and responsibilities as a patient of the practice, and I have been made aware of how to submit a complaint/concern.

Patient Signature: _____ Date: _____

Caregiver and relationship: _____

(if patient is unable to document signature, two persons must be witnesses)

Witness: _____

Witness: _____

PATIENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Practice Notice of Privacy Practices. I have had the opportunity to ask questions regarding the Notice or Privacy Practices and its contents.

Patient Signature: _____ Date: _____

Caregiver and relationship: _____

For Use by Practice Staff Only:

- File this document in the patient's medical record.
- Complete the information below if the patient acknowledgment is not obtained.

The patient was provided a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgment was not obtained because:_____

Staff Signature: _____ Date: _____

Medication Chart

THIS NEEDS TO BE COMPLETED IN IT'S ENTIRETY / DO NOT LEAVE BLANK

PATIENT NAME:	DATE:
PREFERRED PHARMACY (Name/Address):	
ALLERGIES:	

MEDICATION NAME	STRENGTH	BREAKFAST	LUNCH	DINNER	BEDTIME

PLEASE NOTE: OUR OFFICE REQUIRES A 48 HOUR NOTICE ON ALL REFILL REQUESTS

PERMIAN NEPHROLOGY ASSOCIATES, PA

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

Patient Name: _____ Date of Birth: ____/____/_____
E-mail Address: _____

I_____, hereby authorize **Permian Nephrology Associates** to release my Protected Health Information (PHI) for billing, condition, treatment, and prognosis to the following individual(s):

Name _____ DOB_____ Relationship _____
Name _____ DOB_____ Relationship _____
Name _____ DOB_____ Relationship _____
Name _____ DOB_____ Relationship _____

I request the following restriction(s) to releasing my PHI:

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that this authorization will remain in effect until revoked in writing.
I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Patient Signature:_____ Date:_____