ASSOCIATES IN NEPHROLOGY PATIENT REGISTRATION

Name:____
Last First Middle Initial (Jr. Sr. II)

Local Address:____

City/State/Zip:____

Home Phone:______________________Work Phone:____________________Cell Phone:________________

Social Security Number: ________________________**Date of Birth**: _________________ **Gender**: Male Female

Marital Status: Single Married Divorced Widow(er) Employer Name:______________________________

Ethnicity: Caucasian Black Asian Hispanic Native American Other:______________________________

Preferred Language: English Spanish Other:____

Are you full time resident of Florida? Yes No If no, please provide out of state address and phone:

____

Other address City/State/Zip Phone

In case of emergency, notify (not living with you):

Name:_________________________Phone ________________________Relation:____________

Insurance Information (**PLEASE PROVIDE INSURANCE CARDS AND PHOTO ID AT CHECK-IN**).

Primary Insurance Carrier:_____________________________ **Member ID#**_______________________

Note: If members name is different from you, please provide the following information:

Member name: ______________________________ Member date of birth: ______________________

Member's Employer Name:______________________________Employer Phone Number __________________

Secondary Insurance Carrier:_____________________________ **Member ID#**_____________________________

Note: If member's name is different than you, please provide the following information

Member name: ______________________________ Member date of birth: ______________________

Insurance Beneficiary claim authorization and information release

I request that payment of authorized medical benefits be made either to me or on my behalf to Associates in Nephrology for any services furnished me by the providers. I authorize any holder of medical information about me to release to Associates in Nephrology for my Insurance and/or Medicare/Medicaid services and its agents any information needed to determine benefits or the benefits payable for all related services. I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on the HCFA claim form or elsewhere on the claim form or an electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for any deductible, co-insurance and for any non-covered services. I understand and agree that regardless of my insurance status, I will be responsible for the payment of all charges incurred on behalf of myself or family member. NOTE: If your insurance requires a referral for you to see a provider at Associates In Nephrology, it is your responsibility to provide our office with the referral. If your insurance company denies payment **DUE TO NO REFERRAL** – you agree to pay Associates in Nephrology in full for any charges incurred during this visit or any subsequent visit. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this agreement and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. **I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR ANY OF THE ABOVE INFORMATION:**

X______________________________/_________ ______________________________/____________

Signature of patient/guardian/responsible party **Date** **Witness** **Title** **Date**