

ASSOCIATES IN NEPHROLOGY - PATIENT REGISTRATION FORM

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

Local Address: _____ **City/State/Zip:** _____

Northern Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Other:** _____

Email Address: _____ @ _____ .com

Social Security Number: _____ **Date of Birth:** _____ **Gender:** Male Female

Marital Status: Single Married Divorced Widow(er) **Preferred Language:** English Spanish Other: _____

Employer Name: _____ **Employer Phone Number:** _____

Ethnicity: Caucasian Black Asian Hispanic Native American Other: _____

Pharmacy Name: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

In case of emergency, please notify (must have another phone number different from 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:** _____

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 either made 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 family member or myself. 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