HOUSTON NEPHROLOGY GROUP, P.A.

Patient Information Form:

Name:_____Date of Birth: _____

Address:_____

Telephone #:_____ ◯Hm ◯Wk ◯Cell Telephone #:_____ ◯Hm ◯Wk ◯Cell

Sex: ◯Male ◯Female Marital Status: ◯Married ◯Single ◯Divorced ◯Widow(ed) SSN#:_____

Referring Physician:_____Telephone #:_____

Texas Law requires healthcare facilities to ask patients to identify their own race and ethnic background.

Race:

◯ American Indian or Alaska Native

◯ Asian or Pacific Islander

◯ Black or African American

◯ White

◯ Other:_____

◯ Prefer Not to Answer

Language:

◯ English

◯ Spanish

◯ Indian

◯ Russian

◯ Other:_____

Ethnicity:

◯ Hispanic

◯ Not Hispanic

◯ Prefer Not to Answer

Patient Employment:

◯ Employed ◯ Retired ◯ Unemployed ◯ Disabled

Employer:_____Employer's Phone#:_____

Employer's Address:_____

City:_____State:_____Zip:_____

Guarantor: (Where Statements will be mailed to) ◯ **Check if same as Patient**

Guarantor: _____Relationship to Patient:_____

Address:_____Phone#:_____

City:_____State:_____Zip:_____

Doctor and Pharmacy Information:

List all Doctors Patient sees:

Name _____ Phone #:_____

Name _____ Phone #:_____

Name _____ Phone #:_____

Pharmacy Name _____ Phone #:_____

Insurance Information:

1. Insurance Carrier:_____Phone #:_____

   Mailing Address :_____

   City:_____ State: _____ Zip:_____

   Subscriber ID#:_____ Group #_____ Insured Name:_____

2. Insurance Carrier:_____Phone #:_____

   Mailing Address :_____

   City:_____ State: _____ Zip:_____

   Subscriber ID#:_____ Group #_____ Insured Name:_____

This is to certify that I/we, the undersigned, hereby consent to and authorize the administration and performance of all treatments and operations, and the administration of any anesthetics, which, is the judgment of my physician maybe considered necessary or advisable.
I/we, the undersigned agree to be financially responsible for the charges incurred by the patient and to make payments upon receipts of the periodic statements for the patient. In the event of non-payment, I /we agree that if the account is referred to an agency for collection i/we shall be required to pay all the collections expenses.

Signature:_____Date:_____

IF YOUR INSURANCE RQUIRES AN AUTHORIZATION/REFERRAL, PLEASE BE SURE YOU HAVE ONE CURRENT ON FILE OR YOU MAY NEED TO RESCHEDULE YOUR APPOINTMENT.

Emergency Contact Information:

Patient Name:_____Date of Birth:_____

(1) Name:_____ Telephone #_____Relationship:_____

Address:_____ City_____State_____Zip_____

(2) Name:_____ Telephone #_____Relationship:_____

Address:_____ City_____State_____Zip_____

I have voluntarily provided the above contact information and authorize **Houston Nephrology Group, P.A.** to contact any of the above on my behalf in the event of an emergency.

Signature:_____Date:_____

HIPAA Release of Information:

Patient Name:_____Date of Birth:_____

Appointment Information:

Please check all of the following message delivery methods that are available in case we cannot reach you. Please include your daytime/work telephone number. For each number, please authorize name(s) with which we may arrange or confirm your appointment information.

Home Phone:_____ Daytime/Work Phone# _____Cell #:_____

- Can we leave a detailed message on this voicemail? ○YES ○NO
- We may need to arrange or confirm your appointment with:
  ○Self only ○Spouse ○Mother ○Father ○Child ○Other:

Name of Person (if not patient):_____

Medical Information:

With whom may we discuss or disclose your medical information?

Name _____Phone #:_____Relationship:_____

Name _____Phone #:_____Relationship:_____

Name _____Phone #:_____Relationship:_____

I have received a copy of the Notice of Privacy Practices from Houston Nephrology Group, P.A. I will inform Houston Nephrology Group, P.A. with any changes of the above disclosure information.

Patient's Signature:_____Date:_____

Authorization to Release Medical Information:

I authorize Houston Nephrology Group to: ○Release to ○Receive from:

Person orOrganization:_____

Address:_____City:_____ State:_____

Zip:_____ Phone:_____Fax:_____

Information/copies from the Medical Records of:

Patient Name:_____ Date of Birth:_____

Social Security: _____ Date of Service:_____

Information to be released:

○Emergency Room ○Radiology Report ○Lab Work ○Radiology Film

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been reliance on it and the in any event this authorization shall expire in (180) days from the date of my signature unless specified in writing here:_____

I understand that if the recipient authorized to receive the information is not covered entity, e.g. Insurance Company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

To the Party Receiving this Information:

This information has been disclosed to you from records that confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release for information or other information is not sufficient for this purpose.

For Patient Records Applicable under Federal law 42 CFR PART 2:

Signature/Legal Authorized Representative:_____

Print Name: _____Date: _____

Witness:_____ Date: _____

Office Policy – Please Read Carefully

We are providers for several PPO and HMO insurance plans and will be happy to file your claim for you. Co-payments are due prior to seeing the physician at the time of service.

- You are responsible for obtaining any necessary referral or authorization from your primary care physician.
- You are responsible for any non-covered charges.

If you're insurance does not make payment within 45 days, you may be asked to call them for the status of the claim.

Frequently, insurance companies may require additional information from the patient before processing a claim. If you receive such information in the mail, please fill out the form and mail it back to your insurance company as quick as possible. Failure to do so will make you responsible for the entire bill regardless of our contract status. We will expect payment of the deductible and coinsurance amounts at the time of service, or proof that your deductible has been met. We allow 60 days for processing of your insurance claims. At the end of that time, if your insurance has not paid; the entire balance becomes your responsibility.

Medicare:

Houston Nephrology Group, P.A. accepts assignment for our Medicare patients. We will file with Medicare on your behalf but co-insurance is expected at the time of service which is 20% of the Medicare allowable. If your deductible is not met we will collect in full for services rendered.

Medicaid

Houston Nephrology Group, P.A. will file claims to Medicaid on your behalf. You must present a current copy of your Medicaid card at each visit.

No Show Policy

Houston Nephrology Group, P.A. implements a NO SHOW policy. If a patient does not cancel or reschedule their appointment within 24 hours of the appointment date a $25.00 charge will be added to their account.

F our account is over120 days old (4 months) and there has not been any effort to pay the blanance, the account will be reported as a bad debt to the credit Bureau.

Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to rece3ive a copy of this document upon my request.

Please sign below that you have read this office policy and agree to the it's terms. If there is a problem, please speak to the Office Manager before seeing the doctor.

Print Patient's Name:_____

Signature:_____Date:_____