

#  KIDNEY CARE SPECIALISTS, LLC. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Registration

PATIENTS FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FIRST MIDDLE LAST

PATIENTS ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 STREET APT # CITY STATE ZIP CODE
FAMILY DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME ADDRESS PH # FAX #

**PATIENT INFORMATION: SPOUSE OR PARENT/GUARANTOR INFORMATION:**

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male: \_\_\_\_ Female: \_\_\_\_ Single: \_\_\_\_ Married: \_\_\_\_ Widow: \_\_\_\_ Divorced: \_\_\_\_ Separated: \_\_\_\_

Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NAME ADDRESS PH # FAX #

DO YOU HAVE INSURANCE? \_\_\_\_\_ Yes \_\_\_\_\_ No

IF YOU DO NOT HAVE INSURANCE, HAVE YOU APPLIED FOR MEDICAID? \_\_\_\_\_ Yes \_\_\_\_\_ No

**PRIMARY INSURANCE COMPANY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of card holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE COMPANY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of card holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICARE PATIENTS:** DO YOU OR YOUR SPOUSE WORK FOR A COMPANY THAT PROVIDES HEALTH INSURANCE? \_\_\_\_Yes \_\_\_\_ No

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_


**KIDNEY CARE SPECIALISTS, LLC**.

 Patient Authorizations and Billing Policy

**AUTHORIZATIONS**

* I hereby consent to authorize all treatments that may be considered advisable or necessary in judgment by the physician, at my discretion. This consent for treatment and following authorization to bill my insurance company, will remain in effect until I notify Kidney Care Specialists of my withdraw from the practice in writing.
* I authorize Kidney Care Specialists to bill any claims for services by any physician within that group. Regardless of my benefits, I am responsible for any services rendered that are not covered by my insurance.
* I authorize the secure release of my medical information to my insurance company and its agents if needed to determine the eligibility of these benefits and to my referring/family physician via paper or electronic means.

My signature confirms that I have read the authorizations, understand my financial obligation, and agree to the above terms.

 Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **BILLING POLICY**

The following sets forth the general billing policy of Kidney Care Specialists. Please review this and sign where indicated:

* I understand that it is my responsibility to provide the office of Kidney Care Specialists with current and accurate billing information at the time of check in and to notify them of any changes in this information. I understand that the office will also verify my insurance eligibility, deductable and coinsurance amount at that time.
* I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
* I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to re-pay the NSF amount with cash, money order, cashier’s check, or credit card.
* I understand that there is a $20 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the $20 fee (payable prior to completion) is required.
* I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, that the third statement will be marked as “Final Notice” and may be sent to an outside collection service. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
* I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier, in addition to any co-pays, deductibles, etc…

My signature confirms that I have read the billing policies, understand my financial obligation, and agree to the above terms.

 Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**

**KIDNEY CARE SPECIALISTS, LLC**.

 Authorization to Release and Privacy Policy

*All persons listed below must be able to provide us with your date of birth when we are communicating by phone before we will give them any of your Protected Health Information. This is our way to identify them as authorized to receive information about you.*

1. Please list the person’s, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **PLEASE LIST ADDITIONAL NAMES ON THE BACK OF THIS FORM**
2. Please list names other than those above, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**
NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please print the address where you would like to have your billing statement and / or correspondence from our office sent if other than your home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Please print the telephone number where you want to receive calls about your appointments, labs, x-rays results or other health care information, if other than your home phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **\* I am fully aware that a cell phone is not a secure and private line\***
5. Can confidential messages, i.e., appointment reminders, etc. be left on your telephone answering machine or voicemail? YES\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_\_

The Department of Health and Human Services has established a “Privacy Rule” to help insure that Protected health Information (PHI) is protected for privacy. The Privacy Rule also created to provide a standard for health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient to carry on treatment, payment or health care operations. You have a right to review our privacy notice (provided in hard copy upon request) to access your medical record, to request restrictions, and to revoke consent in writing. We reserve the right to revise this notice of privacy practices without notifying patients (so long as it continues to comply with the privacy rule).

As our patient we want you to know that we respect the privacy of your personal medical records and we will do all we can do to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate, we provide the minimum necessary information about treatment, payment, health care operations, in order to provide health care that is in your best interest.

We may have indirect treatment relationships with you (such as laboratories that interact with physicians only) and may have to disclose PHI for purposes of treatment, payment, of health care operations. These entities occur most often and require obtaining patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your PHI. If you chose to give consent in this document, at some future time you may request to refuse all or part of your consent. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

By signing below, I agree with the above information and I understand the Privacy Rule and may receive a copy upon request.

 Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**

**KIDNEY CARE SPECIALISTS, LLC.**

Patient Authorization to Release Medical Records

1362 E. STROOP RD 215 S. ALLISON AVE

KETTERING, OH 45429 XENIA, OHIO 45385

PH: 937-643-0015 PH: 937-376-2571

FAX: 937-643-0016 FAX: 937-376-2930

 Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FIRST MIDDLE LAST

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 STREET CITY STATE ZIP

 Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I GRANT MY PERMISSION FOR THE RELEASE OF
INFORMATION FROM MY MEDICAL RECORDS:**

**TO: KIDNEY CARE SPECIALISTS, LLC TO/FROM: List any doctors having records that could -At any office location be released to us or whom we can release to:
 Dr. Madhu Kandarpa
 Dr. Madhu Kandarpa \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Dr. Arthur Tsai**

 **Dr. Jabulani Sidile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENTS SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**