Kidney Clinic

1425 Highway 34 East
Newnan, GA 30265
Tel: 770-304-3724 Fax: 770-304-3726

130 Governors Square, Suite C
Peachtree City, GA 30269
Tel: 770-376-6256 Fax: 678-545-6872

PATIENT INFORMATION

Name: Last_____**First**_____**MI**_____

Sex (circle one): M F **Social Security #** _____-_____-_____ **DOB:**_____

Address_____

City_____**State**_____**Zip**_____

Home phone _____ **Cell**_____ **Email:**_____

Marital Status (circle one): Married Single Divorced Widowed

Race (circle one): African American Asian/Pacific Islander Hispanic White Other

Employer_____ **Work Phone**_____

Primary Care Physician_____ **Phone #**_____

RESPONSIBLE PARTY INFORMATION (if different from above)
Guarantor Name_____ **Relationship to patient**_____

Social Security # _____-_____-_____ **Guarantor Date of Birth**____/____/_____

Guarantor Address (if different than above)_____

City_____ **State**_____ **Zip**_____

EMERGENCY/CONTACT PERSON
Name_____**Relationship**_____

Phone Home_____ **Work** _____ **Cell**_____

PRIMARY INSURANCE INFORMATION
Company Name_____ **Patient Relationship to Insured**_____

Policy Holder Name_____ **Insurance ID#**_____

Policy Holder Date of Birth____/____/_____ **Policy Holder Social Security #**____-_____-_____

SECONDARY INSURANCE INFORMATION
Company Name_____ **Patient Relationship to Insured**_____

Policy Holder Name_____ **Insurance ID#**_____

Policy Holder Date of Birth_____/_____/_____ **Policy Holder Social Security #** ____-____-_____

GUARANTEE OF PAYMENT: The undersigned agrees to pay all co-pays, coinsurance, deductibles, and charges not covered by the insurance carrier. Should an account be referred to an attorney or a collection agency, the undersigned agrees to pay reasonable attorney's fees, court cost, and collection expenses.
AUTHORIZATION TO RELEASE INFORMATION: (Insurance Carriers)
I hereby authorize the physician/physician office to release any information acquired in the course of my examination and treatment to my Insurance Carriers.
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to Kidney Clinic of all medical benefits otherwise payable to me for services rendered.

Signature of Insured/Guarantor_____ Date____/____/____

MEDICATIONS LIST

Please list below all medications currently being taken. Please include all prescription and over-the-counter medications as well as any vitamins and/or herbals.

PATIENT NAME:_____ DOB:_____

MEDICATION NAME	**DOSE** (20 mg, mcg, ml, etc.)	**FREQUENCY** (daily, twice daily, etc.)

ALLERGIES: Please list below all medication allergies

_____
_____
_____
_____
_____
_____

Kidney
CLINIC

Patient Name:_____ Date of Birth:_____

1. **CONSENT TO MEDICAL CARE AND TREATMENT.** I am being treated at Kidney Clinic ("Physician Office"), and I consent to all medical care, examinations and tests determined by my Physician that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with Physician Office is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.
2. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Kidney Clinic has a detailed document called the “Notice of Privacy Practices for Protected Health Information.” It contains more information about the policies and practices protecting the patient’s privacy. If I ask, Kidney Clinic will provide me with the most current “Notice of Privacy Practices for Protected Health Information (PHI)”

3. **CONSENT TO USE OF INFORMATION.** Electronic Health Records. I understand that the Physician Office may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the Physician Office's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (EHR) will be accessible by Kidney Clinic credentialed physicians/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). The Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my health information with our EHR system, I agree that the Physician Office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

Request for Information from Others. I consent to the Physician Office's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as the Physician Office's participation in any health information exchange described in the Physician Office's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

4. **ASSIGNMENT OF BENEFITS.** I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

5. **FINANCIAL RESPONSIBILITY.** I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary but are later determined unnecessary by the payer.

6. **PERSONAL VALUABLES**. I understand that the Physician Office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physician Office

_____ _____ _____

Patient or Legal Representative Signature Date of Signature Relationship to Patient

KIDNEY CLINIC

Financial Policy

We are committed to meeting your health care needs. In order to keep financial arrangements as simple and cost effective as possible, we have implemented the following guidelines:

1. Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

2. An insurance card is required at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit cards. Any returned checks will result in a $30 returned check fee being added to your account

3. 24-hour cancellation notice required. If no notice is given a $25 no-show fee will be added to your account

4. It is your responsibility to contact your insurance carrier to confirm that our physician participates in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.

5. If your plan requires a referral, it is your responsibility to obtain this authorization prior to being seen by the doctor.

6. All medical record requests MUST be in writing and received in our office a minimum of 72 hours prior to the date needed. We will require the complete name address where records are to be mailed. There is a $10 administration fee and copying fee per page plus postage, for all medical records. This fee must be paid in advance.

** R**emember that you, the patient, are ultimately responsible for payment. ****

I have read and understand the office policy stated above and agree to accept financial responsibility as described.

_____ _____

Patient Name (PRINT) Patient Signature Date

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB_____
Address: _____City:_____State_____
Phone number: _____
Person(s) authorized to speak on my behalf: _____
Phone Number:_____

I authorize representatives from _____ to disclose the following protected health information to the following person/persons.

Please send my health information to:
Name: _____
Address: _____
City: _____State:_____
Phone Number: _____Fax Number_____

Description of Health Information to be Disclosed

- Complete Medical Record (specify dates)_____
- Partial Medical Record (specify records below)

Information to be released

	Dates
○ History & Physical	_____
○ Office notes/Progress notes	_____
○ Consultations	_____
○ Discharge Summary	_____
○ Lab Results	_____
○ Xrays/CT/MRI/Ultrasound	_____
○ Operative Notes	_____
○ Pathology reports	_____

Right and Responsibilities:

1. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization it must be done in writing and presented to Kidney Clinic. I understand that the revocation will not apply to any health information that has already been released.
2. I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.
3. I understand that the health information disclosed may include psychological information, chemical dependence, alcohol abuse, HIV status, and/or Hepatitis.
4. I understand that I am waiving any privilege concerning such information for the purpose of releasing it to the party authorized above. I release Kidney Clinic and its employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me.

_____ _____ _____
Signature of Patient (or Patient's Representative) Date Time

_____
Printed Name