Kidney Care Specialists LLC – Nephrology Associates Division
Patient Registration Information

Date: _____________ Patient Name: ________________________________

Gender: __ Male __ Female __ Other Ethnicity: _________ Marital Status: _________

Address: ____

(#) (Street) (Town) (State) (Zip)

Phone #: ______________________ ________________________ ________________________

(Home) (Cell) (Work)

Date of Birth: _________ Social Security #: _____________ E-mail: __________________________

Emergency Contact: ______________________ Phone: ________________ Type: home/cell/work

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Primary Care Physician: ___________________________ Phone: __________________________

Address: ____

Specialist Name/Type: ___________________________ Phone: __________________________

Address: ____

Specialist Name/Type: ___________________________ Phone: __________________________

Address: ____

Occupation: ______________________________ Employer: ____________________________

Employer Address: ____

Primary Insurance: _________________________ Policy Number: ________________________

Guarantor: __ Self __ Other: ______________________________ _______________

(Name) (Date of Birth)

Secondary Insurance: _______________________ Policy Number: ________________________

Are you covered under either a: __ Union plan __ Employer plan?

Reason for Referral? ____

Pharmacy: ____

(Name) (Address) (Phone Number)

Kidney Care Specialists LLC – Nephrology Associates Division
Financial Policy

Date: _____________ Patient Name: _______________________________

Thank you for choosing Kidney Care Specialists. Our mission is for you to receive the best care and quality service at all times. If you have any questions or concerns about payment policies, please do not hesitate to ask our staff.

Please be aware that Health Insurance Companies require patients to pay their copayment for services at the time of service. We accept cash, Visa, MasterCard, Discover and personal checks. Also, please note that if your insurance changes, we need to be made aware of this prior to your appointment. Failure to provide this information may result in your appointment having to be rescheduled. It is your responsibility that your insurance is current at all times. We may accept assignment of insurance benefits; however, please understand:

1. Our relationship is with you, the patient. Your insurance policy is a contract between you and the insurance company. We are not a party to that contract.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services are due at the time of service.
3. If the insurance company does not pay your balance in full within 60 days, we ask that you contact your carrier to help ensure a timely payment/reimbursement
4. Returned checks are subject to a $50.00 fee
5. **If you fail to show for your appointment, or fail to cancel an appointment without 24 hour's-notice, you will be charged a $50.00 fee.**
6. If your account is sent to collections, you will responsible for the additional collection/processing fees.
7. If you have Medicare ONLY, you are responsible for the twenty percent (20%) balance due which Medicare does not pay. This 20% balance is due at the time of service. You are also responsible for your yearly deductible.
8. **We are legally obligated to collect all patient responsibility fees, copays, deductibles and balances.**
9. We cannot legally discount fees.
10. Any request for medical records will be subject to a fee pursuant to Pennsylvania medical guidelines.

We understand that temporary financial problems may affect timely payment of your balance.
We encourage you to communicate any such problems so we can assist you in the management of your account. Otherwise, payment is expected in full prior to your appointment.

Assignment & Release – I request that payment of authorized insurance be made on my behalf to Kidney Care Specialists – Nephrology Associates Division for any services rendered to me. I authorize any holder of medical information about me to release it to my insurance company and its agents, if information is needed to determine these benefits or the benefits payable to related services. I recognize my financial obligations of any coinsurance, copays, deductibles and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing.

Patient Name : ___________________________________ Date : __________________

Patient Signature : _________________________________

Patient Representative Name: _____________________________ Relationship: ____________

Signature: _____________________________

Kidney Care Specialists LLC – Nephrology Associates Division
Privacy Practices

Date: _____________ Patient Name: _______________________________

Privacy Notice - We are required to provide or make available to you with a copy of our Notice of Privacy Practices to review, which states how we may use/disclose your health information.

(Please initial)
___ I acknowledge that I have received a copy or been given the opportunity to review the Notice of Privacy Practices for Kidney Care Specialists. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Telephone Consumer Protection Act (TCPA)
You agree, in order for us to service your account or to collect monies you may owe, Kidney Care Specialists, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

___ I/We have read this disclosure and agree that Kidney Care Specialists, its employees and/or agents may contact me/us as described above.

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ePrescribing - is defined as a physician's ability to electronically send an accurate and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have been included in an ePrescribe program. These include:

- Formulary and Benefit Transactions – provides prescriber information about what is covered by health plan
- Medication History Transactions – provides prescriber with medications patient is currently taking to minimize adverse effects
- Fill Status Notifications – provides provider with status of refill (picked up, not picked up, partially picked up)

___ I agree that Kidney Care Specialists can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes. I provide informed consent to Kidney Care Specialists to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

HIPAA - You may revoke this consent to the use and disclosure of your protected health information at any time in writing. Any use or disclosure prior to date of your revocation will not be affected.

I give my permission to Kidney Care Specialists to discuss and/or release my protected health information for treatment, payment and health care operations purposes consistent with the Notice of Privacy Practices to my primary care physician and medical specialists (listed on my Patient Registration Information form):

____ **These family members or friends:**
Name: ______________________________ Phone: __________________ Relationship: __________
Name: ______________________________ Phone: __________________ Relationship: __________

Patient Signature: __________________________________ Date: __________________