LAST NAME:	**FIRST NAME :**	**MI:**
STREET ADDRESS	**APT/PO BOX**	
City	**State**	**Zip**
Current Employer		**Full-time Part-time**
Home Phone	**Work Phone**	
Email:	**Ethnicity: Hispanic or Latin Non Hispanic or Latin**	

Race: White Hispanic African American Asian Native American Other

How did you hear about us? Website PCP Specialist Family /Friend Hospital Yellow Pages Other:

Date of Birth	**Social Security No.**
Marital Status Married Single Other	**Referring Dr.**
Cell Phone No.	**Primary Dr.**
Pharmacy	**Pharmacy Phone No.**

Which lab do you use: Quest Labcorp Virtua Memorial Lourdes BC Other

Emergency Contact:	**Phone No.**
Relation to Patient:	**Your Preferred Language:**

INSURANCE POLICY INFORMATION

Primary Insurance Company

Policyholder Name	**DOB**	**SS#**
Insured's ID No.	**Group No.**	

Patient's relationship with insured Self Husband Wife Child Other

Coverage through: Active Employment Retirement Benefit Disability Benefit

Current employer's name:

Secondary Insurance Company

Secondary Insurance Company

Policyholder Name	**DOB**	**SS#**
Insured's ID No.	**State & Zip**	

Coverage through: Active Employment Retirement Benefit Disability Benefit (circle one)

Patient's relationship with insured Self Husband Wife Child Other

Current employer's name:

Medicare Entitlement—Including Medicare HMO Coverage

Is your Medicare entitlement through: Age Disability ESRD Other ______________

Are you currently employed: Yes No Is your spouse employed: Yes No

Do you have group health benefits based on your or your spouse's employment? Yes No

If yes, does the employer have at least 20 employees? Yes No

Privacy Notice

Have you received a copy of The Center for Kidney Care's Privacy Notices? Yes No

Please Sign Here:

____**Date**__________________________

The Center for Kidney Care

ASSIGNMENT OF BENEFITS

I, ___________________________request the payment of authorized insurance benefits to be made on my behalf to The Center for Kidney Care. I authorize The Center for Kidney Care to release to my insurance company and its agents any information needed to determine these benefits.

I understand my signature request that payment be made and authorizes the release of medical information necessary to pay the claims. My signature authorizes the release of information to my insurance company or its agents. In the event my account is sent to a collection agency, an additional 30% fee will be added to my balance.

I understand that I need to give a least 24 hours notice if I need to reschedule an appointment and I agree to pay a $50 fee if I do not show up or if I reschedule an appointment with less than 24 hours notice.

( ) ***Medicare***: The Center for Kidney Care agrees to accept the charge determination of the Center for Medicare and Medicaid services or its agents as the full fee. The patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are determined by CMS or its agents.

( ) ***Medicare*** Supplement: Name of Carrier ____ Policy # ____________________

( ) ***Insurance***: Name of Carrier: ____

The patient is responsible for all deductibles, coinsurance, and non-covered services. It is the patient's responsibility to secure all referrals and pre-approvals for services as outlined in the patient's insurance policy guidelines. Insurance coverage is a contract between the insured (patient) and the insurance company.

Patient Signature: ____ **Date:** ____________________________

****

MEDICAL RELEASE AUTHORIZATION

I, ____, hereby authorize physicians, specialists, and facilities who hold my medical records to release to The Center for Kidney Care, copies of my medical records. I understand this release includes primary care physicians, specialists, medical & diagnostic facilities. I further authorize the release of the name of my insurance carrier and my policy numbers to The Center for Kidney Care. I recognize that the sharing of this confidential information is solely and necessary to facilitate payment for my medical care.

____ __________________________

Patient Signature **Patient Date of Birth**

__________________________ ____________________________

Date **Witness Signature**