J. R. NEPHROLOGY

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(Please Print)

NAME: _____ TODAY'S DATE: ____/____/____
Last First M.I.

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBERS: Home: (____)_____ Cell Phone: (____)_____ Fax: (____)_____

BIRTH DATE: ____/____/____ SOCIAL SECURITY #: _____ SEX: ( ) M ( ) F

MARITAL STATUS: ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

EMPLOYER: _____ PHONE: (____)_____

ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: (____)_____

REFERRING or PRIMARY CARE PHYSICIAN: _____ PHONE: (____)_____

PHARMACY: _____ ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY # _____ GROUP # _____ ID # _____

PRIMARY CARD HOLDERS BIRTH DATE: _____ SOCIAL SECURITY #: _____

SECONDARY INSURANCE COMPANY: _____

POLICY # _____ GROUP # _____ ID # _____

PRIMARY CARD HOLDERS BIRTH DATE: _____ SOCIAL SECURITY #: _____

"I certify that, to the best of my knowledge, the information provided is correct. I request that payment of authorized benefits be made on my behalf. I authorize J.R. Nephrology to release to my insuring agents including but not exclusive to Medicare and/or Medigap any information needed for claims for services provided to me by J.R. Nephrology. I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax."
"I understand and agree that J.R. Nephrology maintains and originates records pertaining to my test results, treatment, and plans for future treatment and care, and that this information may be shared with insurance companies, billing services, third party payers, and any physicians or healthcare facilities contributing to my care. A Photostat of this authorization shall be valid as the original."

Signature: _____ Date: ____/____/____

I certify that I have been offered a copy of the HIPAA Notice of Privacy Practices describing how medical information about me may be used and disclosed and how I can get access to this information. I agree to all the provisions set forth in this brochure.

Signature: _____ Date: ____/____/____

I am providing a password to be used for identification in case I need information or a prescription refill, etc. This password does not contain any of my own identifying information and will be kept private.

Password: _____ Date: ____/____/____

We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Please mark the line beside your selection.

Race

_____ American Indian/Alaska Native

_____Asian

_____Black or African American

_____White Hispanic or Latino

_____Black Hispanic or Latino

_____Native Hawaiian/Other Pacific Islander

_____White

_____Some other race

_____Declined

Do you consider yourself Hispanic/Latino?

_____Yes

_____No

_____Declined

Please provide your language preference. Please note for languages other than English, we request that a translator accompany the patient.

_____English

_____Chinese

_____French

_____German

_____Italian

_____Japanese

_____Korean

_____Portuguese

_____Russian

_____Spanish

If applicable, please provide your email:

_____

Signature: _____ Date: _____/_____/_____