Kidney Care Consultants, P.S.C.

# PATIENT REGISTRATION FORM

**Date:** _____

**Patient's Name:** (Last) _____ (First) _____ (Middle) _____

**Social Security Number:** _____ **Date of Birth:** _____ **Sex:** M F Other

**Marital Status:** Married Single Divorced Widowed **Ethnicity:** Non-Hispanic / Non-Latino Hispanic / Latino

**Race:** African American Asian White American Indian Pacific Islander Other Decline

**Primary Language:** English Spanish Other _____

**Phone Numbers:** Cell: _____ Home: _____ Work: _____

May we leave messages on your phones? Yes No

**Email Address:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**IN CASE OF EMERGENCY NOTIFY:** _____

**Phone:** _____ **Relationship to Patient:** _____

**Referring Provider Name:** _____

**Primary Care Provider Name (if different from referring):** _____

**Pharmacy:** _____ **Zip Code:** _____

**Insurance:** _____ ****PLEASE GIVE CARDS TO FRONT DESK TO COPY****

**Drug Allergies:** _____

**Assignment of Benefits:** I authorize my health insurance to issue payment of benefits directly to Kidney Care Consultants for payment of services rendered. ***Initial and Date:** _____

**I attest the information provided in this registration is accurate and complete. I agree to report any changes in my address, phone number, and/or insurance status. I understand dishonest or misleading information may be cause for termination.**

**Signature:** _____ **Date:** _____

Kidney Care Consultants, P.S.C.

## PATIENT FINANCIAL RESPONSIBILITY POLICY

*As your physicians, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our patient financial responsibility policy.*

- Prior to each appointment, please check your insurance information so you will be informed about referrals, co-payments and any deductibles that are required. Unless arrangements have been made in advance, co-payments, co-insurance, deductibles and any outstanding balances are expected at time of service. A one-time exception may be made at the discretion of the Practice Manager, otherwise your appointment may need to be rescheduled. Payment may be made with cash, check, Visa, MasterCard, Discover and American Express.

- Any check returned from the bank will result in an additional $25.00 charge that will appear on your account.

- Please present your insurance card for verification at every appointment. You are responsible for notifying us immediately of any change in name, address, phone or insurance information.

- Our relationship and concern is with you and your health, not with your insurance company. Please remember that your health insurance contract is between you and your insurance company. Any questions or complaints regarding your coverage should be directed to your insurance company. If your insurance company does not respond to or denies a claim that we have submitted on your behalf, you may be liable for all charges.

- If we are not participating providers with your plan, or you do not have insurance, you are expected to pay in full for all visits and/or procedures.

- *Failure to promptly resolve your balance may result in collection action. If we have not received payment within 30 days of your first statement, you may receive a courtesy call and/or reminder letter regarding your balance. We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact a patient accounts representative at 502-238-9911 for assistance in the management of your account. Please note that making a partial payment without prior approval by a patient account representative will not prevent further collection procedures, up to and including placement with an outside collection agency.*

**I have understood and agreed to the Financial Responsibility Policy for KCC.**

**⇨ Signature** _____ **⇨ Date** _____

**⇨ Print Name** _____ **⇨ Date of Birth** _____

**Witness** _____ **Date** _____

Kidney Care Consultants, P.S.C.

**CONSENT FOR TREATMENT:**
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

***Initial & Date*** _____

**CONSENT TO OBTAIN PRESCRIPTION HISTORY:**
I give my full consent for Kidney Care Consultants to obtain any and all records pertaining to my prescription history.

***Initial & Date*** _____

**RELEASE OF INFORMATION / HIPAA NOTICE OF PRIVACY PRACTICES:**
By signing this form, you are granting consent to KCC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 502-595-7744. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

***Initial & Date*** _____

**MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:**
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

***Initial & Date*** _____

**Patient Signature** _____ **Date** _____

**Printed Name** _____

I authorize Kidney Care Consultants to **disclose personal information about me to the following person(s)**. Information disclosed may include, but not exclusive: account balance, billing information, appointments, treatment, plan of care, and prescriptions. This authorization expires upon my death, unless revoked by me in writing.

***Person*** _____

***Relationship to Patient*** _____

***Person*** _____

***Relationship to Patient*** _____

***Person*** _____

***Relationship to Patient*** _____

*Office Use Only*

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices.

Date: _____ Attempt: _____

Staff Name: _____