RENAL MEDICINE ASSOCIATES

DEMOGRAPHICS:

NAME ____

DATE OF BIRTH ____

ADDRESS ____

CITY ______________________________ STATE________________ ZIP ___________________

HOME PHONE_____________________________ CELL __________________________________

SS# ___________________________ EMAIL ADDRESS __________________________________

EMPLOYER ___________________________________WORK PHONE______________________

EMERGENCY CONTACT ______________________________ PHONE______________________

RELATIONSHIP TO PATIENT____

PRIMARY CARE PHYSICIAN: _________________________ Phone Number:__________________

RACE________________________________ ETHNICITY _______________________________

PREFERRED LANGUAGE ____

RESPONSIBLE PARTY INFORMATION

(IF DIFFERENT THAN PATIENT)

NAME ____

ADDRESS ____

CITY _______________________________STATE _________________ ZIP ___________________

PHONE ___________________________ RELATIONSHIP TO PATIENT _______________________

EMPLOYER __________________________________ WORK PHONE__________________________

INSURANCE INFORMATION

YOU MUST BRING YOUR INSURANCE CARD TO EACH VISIT

PRIMARY INSURANCE ____

SUBSCIBER'S NAME:________________________ SELF____SPOUSE____PARENT____OTHER____

SUBSCRIBER'S ID#_____________________________ SUBSCRIBER'S DOB__________________

SECONDARY INSURANCE:____

SECONDARY INSURANCE SUBSCRIBERS NAME:____

SECONDARY INSURANCE ID #:________________________ SELF____SPOUSE____PARENT______

Renal Medicine Associates will file all of my insurance claims, provided that I inform them of the correct policy information and I have obtained a current referral or prior authorization from my primary care provider as required by my insurance carrier. I understand that I am financially responsible for all services provided.

I request that payment be made to Renal Medicine Associates, LTD on any billed services rendered to me.

CONSENT

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, injections or other medical services as ordered or approved by my physician(s), or any healthcare professional assigned to my care by my physician(s).

During the course of my care and treatment, I understand that various types of examinations, tests, and diagnostic or treatment procedures may be necessary. These procedures may be performed by physicians, nurse practitioners, nurses, medical assistants or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures or injections, I will ask my physician, nurse practitioner or nurse to provide me with additional information.

I have received a copy of the Privacy Act: ☐

APPOINTMENT CONFIRMATION

I give Renal Medicine Associates permission to confirm my appointment forty eight (48) hours in advance of my next appointment and/or authorize representatives of RMA to leave information on my home, cell or work phone numbers.

___I give RMA permission to send correspondence via email.

___I give RMA permission to send text messages to my cell phone.

***** A $30.00 fee may apply if I do not contact the office within twenty four hours (24) to cancel a scheduled appointment*****

___I give Renal Medicine Associates consent to run a Pharmacy History Report.

AUTHORIZING REPRESENTATIVE

I authorize the following person(s) to pick up prescriptions, sign for and pick up medical records and make, confirm or cancel my appointments.

1. ____Relationship ___________________________________

2.____ Relationship__________________________________

____ ______________________________

Patient/Parent/Guardian/Authorized Representative Date