PRIMARY INSURANCE

INSURED'S NAME: ____

INS. CO. NAME: ___________________________________ ID # _______________________ GROUP: ______________

ADDRESS: _______________________________________ CITY: _________________STATE: _______ ZIP: ____________

IF SOMEONE OTHER THAN YOURSELF CARRIES THE POLICY, PLEASE FILL OUT:

HIS/HER NAME: ______________________________ RELATIONSHIP: _______________

SOCIAL SECURITY #: __________________________ DATE OF BIRTH: _______________

PLACE OF EMPLOYMENT: ____

ADDRESS (IF DIFFERENT FROM PATIENT: ____

SECONDARY INSURANCE

INSURED'S NAME: ____

INS. CO. NAME: ___________________________________ ID # _______________________ GROUP: ______________

ADDRESS: _______________________________________ CITY: _________________STATE: _______ ZIP: ____________

IF SOMEONE OTHER THAN YOURSELF CARRIES THE POLICY, PLEASE FILL OUT:

HIS/HER NAME: ______________________________ RELATIONSHIP: _______________

SOCIAL SECURITY #: __________________________ DATE OF BIRTH: _______________

PLACE OF EMPLOYMENT: ____

ADDRESS (IF DIFFERENT FROM PATIENT: ____

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Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance, and other health plans to NEPHROLOGY AND HYPERTENSION ASSOCIATES, LLC. (Thomas D. Wooldridge, M.D.; J. Martin Lee, Jr., M.D.; Tzonko V. Milev, M.D.; Morris R. Hamilton, M.D.; Christopher D. Miller, M.D.; Marcus Louis Britton, M.D.; Son G. Lam, M.D.; Patricia S. McKnight, CFNP; Christy Jaggers, NP; Kathy Thomas, AGACNP; Trenton Gray, FNP-BC). This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signed: ____ Date: ___________________________

Responsible Party: ____ Date: ___________________________

I have **no insurance coverage** of any type and I understand that I am fully responsible for any charges that may incur at Nephrology and Hypertension Associates, LTD.

Signed: ____ Date: ___________________________

Responsible Party: ____ Date: ___________________________