NEPHROLOGY & HYPERTENSION ASSOCIATES, LTD.

Patient Name:		Email:	
Address:	STREET: _____ _____ CITY: _____ STATE: _____ ZIP: _____	Phone:	Home: _____ Mobile: _____ Work: _____
Sex:		Race:	
DOB:		Language:	
SOCIAL SECURITY #:		MARITAL STATUS:	
PRIMARY CARE PROVIDER:			

EMERGENCY CONTACTS:

Name:		Name:	
Relation:		Relation:	
Phone:		Phone:	

INSURANCE COVERAGE: **PLEASE BRING YOUR CARDS TO YOUR VISIT**

****If pre-cert is required for initial visit, this will be the responsibility of the patient or the patients referring provider. This must be obtained prior to the first appointment.**

	Primary Insurance		Secondary Insurance
Payor:		Payor:	
Subscriber Name:		Subscriber Name:	
Relation:		Relation:	
Sub ID:		Sub ID:	
Group #:		Group #:	

Patient Signature: _____ **Date:** _____

**** please bring your medication bottles with you to your visit****

PATIENT NAME: _____

NEPHROLOGY & HYPERTENSION ASSOCIATES, LTD.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Nephrology and Hypertension Associates, LTD. Notice of Privacy Practices. (**If you would like a copy of the Privacy Policy for Nephrology and Hypertension Associates, LTD., this can be obtained as you check in for your visit, calling our office to request a copy be mailed to you, or by visiting our website at https://nephrologyassociatesms.com)**

SIGNATURE OF PATIENT: _____ DATE: _____

PLEASE LIST THREE PEOPLE (FAMILY/FRIENDS) WHO MAY CONTACT US REGARDING YOUR PROTECTED HEALTH INFORMATION:

1. _____

2. _____

3. _____

☐ By checking I acknowledge that I do not want my health information discussed with anyone who may call this office with the exception of other healthcare providers.

FOR USE BY OFFICE PERSONNEL ONLY: (COMPLETE IF PATIENT ACKNOWLEDGEMENT NOT OBTAINED)

The patient was provided a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice.

An acknowledgement was not obtained because _____

Signature of office personnel: _____ Date: _____

NEPHROLOGY & HYPERTENSION ASSOCIATES, LTD.

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the release of medical records to NEPHROLOGY AND HYPERTENSION ASSOCIATES. The records should be from the health record of:

_____
Patient Name

_____
Patient DOB:

Records Requested:

☐ Entire Patient Record

☐ _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

This facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed _____
Patient or Representative

_____
Relationship to Patient

_____
Date of Signature

NEPHROLOGY & HYPERTENSION ASSOCIATES, LTD.

Cancellation/No-Show Policy/Late policy

Quality care for our patients is our top priority. Please take a few moments to review of our no-show policy and sign at the bottom of the form. If you have questions, please let us know.

Definition of a "No-Show" appointment

Nephrology and Hypertension Associates defines a "No-Show" appointment as any scheduled appointment in which the patient does not arrive for the appointment.

Impact of a "No-Show" appointment

"No-Show" appointments have a significant impact on our practice and the healthcare we provide our patients. When a patient "No-shows" for a scheduled appointment it:

- Potentially jeopardizes the health of the patient is a "No-show"
- Prevents another patient from being scheduled in that time slot.
- Effects the providers time negatively.

How to avoid "No-Show" appointment

- Provide the receptionist with a current phone number and address at EVERY visit.
- Confirm your appointment date and time when receiving a reminder call.
- Arrive 15 minutes early to complete any necessary paperwork at each visit.
- Come prepared with your most recent insurance card and a picture ID at EVERY visit.
- Give at least a 24 hour notice when cancelling your appointment.

Consequences of a "No-show" appointment

If you have three (3) no show appointments in your record within a year, you may be discharged from the practice.

Late arrival policy

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

_____ _____

Patient Signature or Patient Representative **Date**

NEPHROLOGY & HYPERTENSION ASSOCIATES, LTD.

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: _____

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: _____

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.; Amita Maibam, M.D.; J. William Elliott, D.O.; Nathan Bell, D.O.; Vikram B. Beemidi, M.D.; Calvin C. Baker, M.D., Patricia S. McKnight, CFNP; Kathy Thomas, AGACNP; Christy Jaggers, FNP-BC; Fred A. Rayburn, FNP-BC; Jamesha Tumblin, DNP-BC; Brandy M. McCain, 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.

_____ _____

Patient or 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.

_____ _____

Patient or responsible party: Date: