# Nephrology Consultants, L.L.C.

2780 Bob Wallace Avenue, N.W. • Huntsville, Alabama 35805-4104 • Phone (256) 533-4626 • Fax (256) 533-4710

Patient Name:______________________________________________

Sex: Male( ) Female( ) Date of Birth___/___/___ Age: ____ S.S.#____________________

Marital status (circle one): Single Married Widowed Divorced Driver's License #____________

Patient Address:______________________________________________

City/State:______________________________ Zip Code:______________

Home Phone:________________________ Cell Phone: ____________________

Email address:______________________________________________

Name of Employer:______________________________________________

Occupation:______________________ Business Phone:__________________

Race:__________ Ethnicity(check one): Hispanic___ Non-Hispanic___ Language:__________

Name of Spouse or Parent (if patient is a minor):______________________________
Date of Birth:___/____/____ S.S.#:____________________

Person Responsible for this Account:______________________________________
Self( ) Spouse( ) Parent( ) Date of Birth:____/______/______ S.S.#__________________

Primary Care Physician:________________________ City/State ______________

*Emergency Contact:________________________ Phone:______________

Relationship to Patient:______________________________________________
*include Emergency Contact on HIPAA Authorization Form

Primary Insurance:________________________Policy#:__________________

Group #:______________________ Subscriber:________________________

Subscriber Date of Birth:______________________________________

Secondary Insurance:______________________Policy#:__________________

Group #:______________________ Subscriber:________________________

Subscriber Date of Birth:______________________________________

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Patient Name ______________________________ Date of Birth ________________

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE

I request that payment of authorized insurance carrier benefits be made on my behalf to Nephrology Consultants for any service rendered me by the physician. I understand the holder of medical information about me may release my medical information to my insurance carrier and its agent for the purpose of determination of these benefits payable for related services.

______________________________ ________________

Patient Signature Date

I authorize payment of medical benefits to Nephrology Consultants for any services furnished me by the physician/staff. I understand that I am financially responsible for any amount not covered by my contract. I authorize you to release to my insurance company, or agent, information concerning health care, advice, or treatment provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

______________________________ ________________

Patient Signature Date

*** There is a $25.00 fee for all "No Show" appointments. This is not billed to insurance and is the responsibility of the patient to pay. If you must miss your appointment, please notify our office 24 hours in advance of the appointment.

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## AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Date: ______________________________

To: ______________________________

______________________________

I authorize you to release to: Nephrology Consultants, LLC

All records: including Labs, Renal Ultrasounds, and Physician Notes

______________________________

Patient Signature (Parent Signature, if patient is a minor)

______________________________

Date of Birth

______________________________

Social Security Number

______________________________

Witness

# Nephrology Consultants, L.L.C.

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HIPAA Revision Effective 9/23/2013

Date: ______________________

Patient Name: ______________________ Date of Birth: ______________________

Due to changes to the HIPAA guidelines, we need your specific instructions on how to handle your protected medical records.

Please complete this form and return to us at your earliest convenience.

The staff of Nephrology Consultants, L.L.C has my permission to discuss the following with the person(s) listed below regarding: medical records__________ financial information______________

Name: ______________________ Name______________________

Name: ______________________ Name______________________

Name: ______________________ Name______________________

Specific disclosure forms are required for: Fundraising, marketing, mental health records and for records of patients who pay in full and do not wish to have information disclosed to an insurance carrier.

If there is a breach in your protected information you will be notified in writing.

I have received the HIPAA guidelines effective 9/23/2013.

______________________________

Patient Signature