Patient Information

Patient Name: ____ Sex: ___________ DOB: _______
Soc Sec Number: ____-__-___ Primary Care Physician: _____________________________________
Address: ____
Phone: ________________________ Cell: _____________________ Work: ______________________
Marital Status: _________________________________ Email: ___________________________________
Occupation: _____________________________________ Employer: ______________________________
Preferred Method of contact: Phone Mail Email: ______________________________
Ethnicity: Hispanic/Non-Hispanic Race: Caucasian African American Hispanic Asian Am Indian
Other: ____

Uninsured

I do not have insurance and understand that I am financially responsible for the charges incurred.
Patient Signature: ____

Primary Insurance

Primary Insurance Co: ____
Policy Holder Name: ______________________________________ DOB: ____________________
Social Sec Number: _________________ Relationship to Patient: ___________________________
Policy ID: ________________________ Group: ____________________________________

Secondary Insurance (If Applicable)

Secondary Insurance Co: ____
Policy Holder Name: _____________________________________ DOB: ____________________
Social Sec Number: _________________ Relationship to Patient: __________________________
Policy ID: _________________________ Group: ______________________________________

Financial Agreement/Consent to File Insurance

I hereby agree to be responsible for charges covering all services rendered by Nephrology Associates of MI, PC. I shall also be responsible for any legal and/or attorney fees required to collect for these services to which interest may be added at the current legal rate. I hereby assign directly to Nephrology Associates of MI, PC for payment of my health insurance benefits applicable to these services and authorize the collection of such funds on my behalf. Such payments shall not exceed my balance owed to Nephrology Associates of MI, PC. I acknowledge and understand that I and any guarantor signing on my behalf are personally responsible for all charges not otherwise paid by assignment to insurance benefits. I also certify that any information, which I have provided, is true and correct. If I provide Nephrology Associates of MI, PC or its agents with my cell phone number, I authorize Nephrology Associates of MI, PC or its agents to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe. I understand that any email I provide is my personal e-mail and I authorize Nephrology Associates of MI to contact me at that e-mail address.

Signature of Responsible Party/Patient Signature

Patient Signature: _________________________ Date: __________ Staff Initials: _____________

General Consent to Medical Treatment

I request and authorize Nephrology Associates of MI, their physicians, and their associates and assistants who may attend to me during any visit, to provide medical care and other services as prescribed for me for

my health and well-being. I acknowledge that no representations, warrantied, or guarantees as to the results have been made to me by Nephrology Associates of MI, nor have I relied upon any such representations, warranties, or guarantees.
Initials: _______________ Date: _______________

Missed Appointments

I hereby agree to be responsible for a charge of $50.00 which may be assessed by NAM for appointments missed or cancelled with less than 24-hour notice. I understand these charges will not be submitted to my insurance company. Initials: ______________________ Date: __________________

Communication of Private Health Information Authorization

Please check and fill out all that are acceptable forms of communication to provide quality patient care

___ I authorize the staff or NAM and or the iremind system to leave a message regarding my private health information on my home voicemail or answering machine.

___ I authorize the staff of NAM and or the iremind system to leave a message regarding my private health information on my cell phone voicemail.

___ I authorize the staff of NAM to leave a message regarding my private health information on my work voicemail or answering machine.

___ I authorize the staff of NAM to speak with the following individuals to discuss medical/and or financial information.

MEDICAL:

NAME	PHONE	RELATIONSHIP TO PATIENT

FINANCIAL:

NAME	PHONE	RELATIONSHIP TO PATIENT

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP TO PATIENT

HIPAA Privacy Notice Acknowledgement

By signing below, I acknowledge that I have been advised of the Notice of Privacy Practices of Nephrology Associates of MI(NAM) and may obtain a written copy upon request.
Patient Signature: ___________________________________ Date: _______________________