NEPHROLOGY SPECIALISTS OF OKLAHOMA

Excellence in Kidney Care

DATE: ________________________

NAME ____ DATE OF BIRTH ___________________ SSN ______________

ADDRESS ____________________________________ CITY ______________________ STATE ______ ZIP ____________

HOME PHONE (___)_________________ CELL PHONE (___)_________________ E-MAIL _________________________

Sex: M F **Race: Black/ African American American Indian White/Caucasian Other**_____________________

Ethnicity: Hispanic or Non-Hispanic **Language:** English Spanish Other: _________________

Marital Status: Single Married Divorced Widowed Long Term Partner Separated

Spouses Name: _________________________________ Date of Birth ___________________ SSN __________________

Emergency Contact Information:

Name____________________________________ Phone_____________________ Relationship____________________

Name____________________________________ Phone_____________________ Relationship____________________

Employment Status: Full time Part time Self Employed Retired Disabled Active Duty Student

Employer ____ Phone Number (____) _____________________

REFERRING PHYSICIAN__________________________________ Phone_____________________ Fax________________

Address ______________________________ City __________________________ State_______ Zip Code____________

PRIMARY CARE PHYSICIAN______________________________ Phone_____________________ Fax ________________

Address ______________________________ City __________________________ State_______ Zip Code____________

PATIENT CONSENT:

CONSENT FOR ROUTINE MEDICAL TREATMENT: Nephrology Specialists of Oklahoma and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for the purpose of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

X____

Patient or authorized signature Relationship to Patient Date

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NAME ____ DATE OF BIRTH _______________________

INSURANCE INFORMATION:

Primary Insurance ____ Effective Date________________________

Policy/ID Number ____ Group Number________________________

Claim Address ____ Phone Number________________________

Policy Holder Name ____ Date of Birth__________________________

Policy Holder Employer____

Secondary Insurance ____ Effective Date________________________

Policy/ID Number ____ Group Number________________________

Claim Address ____ Phone Number________________________

Policy Holder Name ____ Date of Birth__________________________

IF your Insurance is **Indian Health**, please list which Nation ____

If your Insurance is **TRICARE, CHAMPUS**, OR **CHAMP VA**:
Sponsor Name_____________________________________ Date of Birth______________ SSN__________________

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

FINANCIAL RESPONSIBILITY: As consideration for the services provided to you, you guarantee payment for any amounts due for such services provided by Nephrology Specialists of Oklahoma. Charges for services and goods shall be at Nephrology Specialists of Oklahoma billed charges rates unless otherwise agreed to in writing by Nephrology Specialists of Oklahoma. I hereby assign to Nephrology Specialists of Oklahoma all payments for medical services rendered to myself or my dependents. I understand that I am responsible for amounts not covered by insurance. I further understand it is my responsibility to notify Nephrology Specialists of Oklahoma of all address, phone number, and insurance information changes. Medicare recipients are responsible for 20% of allowed charges, deductibles, and co-insurance amounts. Other insurance patients are responsible for their co-payments and deductible at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS: You agree that insurance benefits for Nephrology Specialists of Oklahoma charges payable for the insured are to be made payable to Nephrology Specialist of Oklahoma and that insurance benefits for services provided by physicians in the practice setting, otherwise payable to the insured are to be made payable to the physician(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bills for which you are liable, subject to the rules of coordination of benefits.

PATIENT'S CERTIFICATION: I hereby certify that I have read each of the above statements and that I am the patient or legally authorized representative to accept the terms of this patient agreement and may receive a copy of this patient agreement.

Payments are due at or before time of service unless other arrangements were made with our office prior to services.

X____

Patient or authorized signature Relationship to Patient Date

A photo copy of this authorization and assignments shall be considered as valid as the original.

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NAME ____ DATE OF BIRTH ______________________

Local Pharmacy__________________________________ Phone (____)_____________ Fax (____)______________

Address ____________________________ City _________________________ State_______ Zip Code____________

Mail Order Pharmacy _________________________________ Phone (____)___________ Fax (____) _____________

Address ____________________________ City _________________________ State_______ Zip Code____________

Name of Prescription Insurance ____

Is this a Medicare Part D Plan? YES or NO Member Service Phone (___) _______________________

ID # _________________ RxBin ________________ RxPCN __________________ Rx Group ___________________

Exact Name on Prescription Card ____

List all prescriptions, medications, including aspirin, laxatives, cough medications, birth control, etc..

Name	Dose	Frequency	Last dose

List all Allergies: (Drug or Other)

________________________ ________________________ ________________________
________________________ ________________________ ________________________
________________________ ________________________ ________________________
________________________ ________________________ ________________________

X____

Patient or authorized signature Relationship to Patient Date

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NAME ____ DATE OF BIRTH _______________________

AUTHORIZATION FOR ACCESS OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

If you would like Nephrology Specialists of Oklahoma to be able to talk in person or on the phone to anyone including spouse or family members regarding your appointments, medical results or provide any medical information, you will need to list them below.
I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of Individual/Facility/Company to receive Protected Health Information

Name: ____
Address: ______________________________________
____
Relationship: __________________________________

Name: ____
Address: ______________________________________
____
Relationship: __________________________________

Information authorized for use or disclosure, or to be obtained:
_____ All medical information concerning this patient
_____ Medical information of this patient compiled between ___________________ to ____________________

I understand that I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices.

NOTICE OF PRIVACY PRACTICES

CONSENT OF DISCLOSURE OF INFORMATION: Patient medical records and billing information are created and retained by Nephrology Specialists of Oklahoma and are accessible to its personnel and medical staff for use in your care. Nephrology Specialists of Oklahoma personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Nephrology Specialists of Oklahoma is authorized to disclose all or part of my medical record to any insurance carrier, workers' compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Nephrology Specialists of Oklahoma's charges, and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease. You understand that your medical information may indicate that you have or have been treated for psychological or psychiatric conditions or substance abuse. By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing, addressed to Nephrology Specialists of Oklahoma, except to the extent we have already acted in reliance on it.

A complete description of how your medical information will be used and disclosed by Nephrology Specialists of Oklahoma is in our NOTICE OF PRIVACY PRACTICES, which can be given to you by Nephrology Specialists of Oklahoma at your request.

X____
Patient or authorized signature   Relationship to Patient   Date