Renal Consultant PC

Patient Demgraphics/ Information

DATE:	PERSONAL INFORMATION	PLEASE PRINT CLEARLY

Marital Status: (CIRCLE ONE) >>>> Single - Married - Separated - Divorced - Widowed - Other

DATE OF BIRTH:	AGE:	SOCIAL SECURITY #: - -

Last Name: First Name: Mid Initial: Suffix:

Home Address: Bldg/Apt #

City: State: ZIP:

Home Number:	Cell Number:	Work Number:

1-Emergency Contact Name: Phone# Relationship:

2-Emergency Contact Name: Phone# Relationship:

Circle One >>> Employed -Unemployed - Retired - Disabled - Student	Employer Name:	Occupation:

Employer Address: City: State: ZIP:

PRIMARY Insurance Plan:	Insurance Phone#	*Circle one:* Medicare, Medicaid, HMO, PPO, Medicare Adv, Other
Contract#/Enrolee ID #	GROUP#	CoPay Amt: $ Co-Insurance: %

Insurance Address: City: State: ZIP:

******* IF THE PATIENT IS NOT THE SUBSCRIBER - WE NEED THE FOLLOWING INFORMATION BELOW *******

Name of Policy Holder: SOCIAL SECURITY NUMBER:

DATE OF BIRTH: Relationship to patient: Phone#

Policy Holder's Address: City: State: ZIP:

SECONDARY Insurance Plan:	Insurance Phone#	*Circle one:* Medicare, Medicaid, HMO, PPO, Medicare Adv, Other
Contract#/Enrolee ID #	GROUP#	CoPay Amt $

Insurance Address: City: State: ZIP:

******* IF THE PATIENT IS NOT THE SUBSCRIBER - WE NEED THE FOLLOWING INFORMATION BELOW *******

Name of Policy Holder: SOCIAL SECURITY NUMBER:

DATE OF BIRTH: Relationship to patient: Phone#

Policy Holder's Address: City: State: ZIP:

Signature of Patient or Responsible Party Date Relationship to Patient

RENAL CONSULTANT, PC

RESPONSIBILTY AND AUTHORIZATION FORM

1. Individual's Financial Responsibility

- I understand that I am responsible to make sure that Dr. Gampala Reddy is "In-Network" with my insurance plan. While some insurance plans have Out-of-Network benefits, my portion of financial responsibility may be higher, than the In-Network rate.
- I understand that I am financially responsible for my health Insurance deductible, coinsurance, copay and/or non-covered services.
- **Co-Payments are due at the time of service.**
- If my plan requires a referral, I must obtain it prior to my visit.
- If my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided
- If I am Uninsured, I agree to pay for medical services rendered to me at the time of service.
- I understand that I am responsible to inform the doctor's office of any changes in my insurance, address, and/or contact information prior to my appointment.

2. Insurance Authorization for Assignment of Benefits

- I hereby authorize and direct payment of my medical benefits to Renal Consultant PC, on my behalf for any services furnished to me by Dr. Gampala Reddy, MD.
- I understand that the practice of medicine is not an exact science, and I acknowledge that no one has made any representation, guarantee or warranty to me regarding the results to be achieved by any examinations or treatments that I (or the patient) will receive because of services.

3. Authorization to Release Records

I hereby authorize Renal Consultant PC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical providers.

I have read the financial policies contained above, and **my signature below serves as acknowledgement of a clear understanding of my financial responsibility**. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full, within 30 days of notice per statement sent to your address on file.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Printed Name of Patient /Responsible Party Relationship to patient

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about your rights and how we may use or disclose your protected health information. The HIPAA (Health Information Portability and Accountability Act of 1996) Privacy Policy forms are available immediately upon request or on our website **www.nephclinic.com** by clicking *PATIENTS* then *FORMS*.

By signing this form in the acknowledgement box below, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- Renal Consultant PC has made their "Notice of Privacy Practices" document available to me.

******Notice of Privacy Practices Acknowledgement:**

_____	_____	_____
Printed Patient Name	**Signature of Patient, Parent of Legal Guardian**	**Today's Date**

Release of PHI (Protected Health Information)

Under the requirements of The HIPAA Law, we are not allowed to give PHI (Protected Health Information) such as test results, procedures, and/or financial information to any individual without the patient's signed consent.
If you would like to authorize Renal Consultant PC to release your Protected Health Information to any individual, (e.g., spouse, parent, child, friend, etc.), please list individuals below and sign in the acknowledgement box below:

Name: _____Relationship to Patient: _____Phone#_____

Name: _____Relationship to Patient: _____Phone#_____

Detailed voicemail messages regarding my healthcare and/or test results can be left on my:
(Check all boxes that apply and print phone number) If nothing is documented, no message will be left.

- ☐ My Cell Phone Number: _____
- ☐ My Home Phone Number: _____
- ☐ My Work Phone Number: _____

******Release of PHI Acknowledgement:**

_____	_____	_____
Printed Patient Name	**Signature of Patient, Parent of Legal Guardian**	**Today's Date**

RENAL CONSULTANT, PC

CANCELLATION/NO SHOW POLICY

To provide quality care, we have implemented an appointment/cancellation policy.
Please be courteous and call the office promptly if you are unable to attend your appointment. **If you need to cancel or reschedule an appointment please contact our office as soon as possible, and No Later than 24 hours Prior to your Scheduled Office appointment.**
Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care. Cancellation fees are NOT covered by your insurance.

- **If an appointment is not cancelled 24 hours prior to your appointment you will be charged a $25 fee; this will not be covered by your insurance.**
- **If you miss your appointment without calling 24 hours in advance to cancel, the $25 fee will apply due to 'no-show.'**
- **After 3 No-shows, future appointments will be scheduled at our discretion.**
- **We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. Should you experience extenuating circumstances, please contact our Office Manager to discuss.**

***Please be advised due to our Physicians unforeseen emergency or circumstances, your scheduled appointment time may run over unexpectedly. We apologize for any inconvenience that this may cause you and we greatly appreciate your cooperation.

I have read and understand the cancellation/No-Show Policy and agree to its terms and conditions.

Print Name	Date of Birth
Patient Signature or Patent/Legal Guardian	Todays Date

A PATIENT-CENTERED MEDICAL HOME IS A PARTNERSHIP AGREEMENT BETWEEN YOU AND YOUR PHYSICIANS

Being part of a Patient-Centered Medical Home Neighbor, as your Specialist at Renal Consultant PC, I agree to:

- Respect your privacy and keep information confidential as per HIPAA regulations
- Engage in open and honest discussions of all treatment options with you, and help keep your healthcare affordable
- Communicate with your Primary Care Physician about treatment plans, medications, tests orders and test results
- Work with your Primary Care Physician to coordinate all aspects of your care
- Be available to discuss your healthcare at scheduled office visits, during business hours, or if necessary, by phone after hours
- Have appointments available for urgent problems and appointments within 1 - 3 weeks available depending on your medical needs

It is our goal to provide you with the highest level of patient care.
We welcome your feedback, encourage your health care participation, and look forward to working with you toward your good health.

Being part of a Patient-Centered Medical Home Neighbor, as your patient, I agree to:

- Make sure my doctor knows my entire history
- Tell me doctor all the medications I am currently taking
- Actively participate with my doctor in planning my care and follow any recommendations
- Keep my appointments as scheduled
- Inform office of any changes in address and/or phone number
- Inform the office if I change my primary care physician
- Understand my insurance, what it covers and update the office with any changes to my insurance and pharmacy
- Frequently sign into my medical record portal to update my medical history, review messages, and communicate with my providers when necessary
- Ask my doctor questions about things I do not understand
- Ask my other health care providers to send my doctor information such as lab or test results, x-rays, or treatment notes
- Provide the office with feedback on how they can improve

PATIENT / PROVIDER PARTNERSHIP AGREEMENT

Patient Signature_____ Date_____

Patient Printed Name _____