PATIENT INFORMATION

PATIENT NAME:____ SEX:____________ DOB:_________________

SOCIAL SECURITY NUMBER:__________________________ FAMILY CARE PHYSICIAN:_________________________________

ADDRESS:____

CITY:____ STATE:__________ ZIP:_________________

HOME PHONE:_____________________________ CELL:_________________________ WORK:__________________________

MARITAL STATUS: ______Married - Single - Widowed - Divorced - Minor_____ EMAIL:_________________________________

OCCUPATION:____ EMPLOYER:____

PREFERRED METHOD OF CONTACT:___(Circle One) Phone Mail Both___ ETHNICITY: _(Circle One) Hispanic - Non-Hispanic_

RACE: ___(Circle One) Caucasian - African American - Hispanic - Asian - American Indiana - Other______

UNINSURED

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

Patient Signature:____

PRIMARY INSURANCE

PRIMARY INSURANCE COMPANY:____

POLICY HOLDER NAME:____ DOB:__________________________

SOCIAL SECURITY NUMBER:_____________________________ RELATIONSHIP TO PATIENT:_________________

POLICY ID:__________________________________ GROUP:________________________________

SECONDARY INSURANCE (If Applicable)

PRIMARY INSURANCE COMPANY:____

POLICY HOLDER NAME:_______________ _____________________________ DOB:__________________________

SOCIAL SECURITY 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 Indiana Nephrology & Internal Medicine, 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 Indiana Nephrology & Internal Medicine, PC and Physicians 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 Indiana Nephrology & Internal Medicine, 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 given in applying for coverage under the Social Security Act, or any insurance or other information, which I have provided, is true and correct. If I provide Indiana Nephrology & Internal Medicine, PC or its agents with my cell phone number, I authorize Indiana Nephrology & Internal Medicine, 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 e-mail I provide is my personal e-mail and I authorize Indiana Nephrology & Internal Medicine, PC or its agents to contact me via that e-mail address.

SIGNATURE OF RESPONSIBLE PARTY/PATIENT SIGNATURE

PATIENT SIGNATURE:______________________________________ DATE:_________________ STAFF INITIALS:_______________

GENERAL CONSENT TO MEDICAL TREATMENT

I request and authorize Indiana Nephrology & Internal Medicine, PC, their physicians, their associates and assistants who may attend to me during any visit, to provide drugs, medical care and other services as prescribed for me for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to the results have been made to me by Indiana Nephrology & Internal Medicine, PC nor have I relied upon any such representations, warranties, or guarantees.

INITIALS:____________ DATE:_____________

PATIENT NAME: ________________________________ DOB: ________________

MISSED APPOINTMENTS

I hereby agree to be responsible for a charge of $50.00, which may be assessed by Indiana Nephrology & Internal Medicine, PC for appointments missed or cancelled with less than 24 hour notice. I understand these charges will not be submitted to my insurance.

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 of Indiana Nephrology & Internal Medicine, PC 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 Indiana Nephrology & Internal Medicine, PC and/or the iremind system to leave a message regarding my private health information on my cell phone voicemail.
- ☐ I authorize the staff of Indiana Nephrology & Internal Medicine, PC to leave a message regarding my private health information on my work voicemail or answering machine.
- ☐ I authorize the staff of Indiana Nephrology & Internal Medicine, PC to speak with the following individuals to discuss medical and/or financial information.

Medical:

Name	Phone Number	Relationship to Patient
____________________	____________	____________________
____________________	____________	____________________

Financial:

Name	Phone Number	Relationship to Patient
____________________	____________	____________________
____________________	____________	____________________

Emergency Contact: (Please list one individual not living at the same address)

Name	Phone Number	Relationship to Patient
____________________	____________	____________________
____________________	____________	____________________

All information signed and authorized by me on this form shall remain in effect until my written revocation

INITIALS:____________ DATE:_____________

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been advised of the Notice of Privacy Practices of Indiana Nephrology & Internal Medicine, PC and may obtain a written copy upon request.

Patient Signature:____ Date:____________________

STAFF USE ONLY

Indiana Nephrology & Internal Medicine, PC personal witnessing form completion: ______________________________

Date:_______________________