NEPHROLOGY ASSOCIATES

Compassionate Kidney Disease Diagnosis and Treatment
Promoting Quality of Life + Independence

Nephrology Associates, PC | 129 N Brookmoore Drive | Columbus, MS 39705
Office: (662) 329-3838 | Fax: (662) 329-2515 | www.nakidneydocs.com

PATIENT DATA FORM

Date:_____ Referred by:_____

Patient Name:_____
First Middle Last

Address:_____
Street City State Zip

Date of Birth:_____/_____/_____ Social Security # _____

Home Phone:_____

Mobile Phone:_____

Other Phone:_____

Email Address:_____

****Please circle your preferred method of phone contact from above choices****

May we leave voice message on your preferred method of phone contact? YES ☐ NO ☐

Do you prefer an electronic appointment reminder? YES ☐ NO ☐

If yes, Please circle one or both: TEXT MESSAGE ☐ EMAIL ☐

List names of persons and relationship (i.e., wife) at contact numbers with whom your appointment information may be shared:

_____
(Print Names and Relationship)

Preferred Language: English ☐ OR Other: _____ Gender: Male ☐ Female ☐

Race:_____ Ethnicity (i.e. French):_____

Occupation:_____Employer:_____City:_____ State:

EMERGENCY Contact:
Name Telephone Number Relationship

Address:
Street City State Zip

INSURANCE INFORMATION

Primary Insurance:_____ **Secondary Insurance:**_____

Policy Number:_____ **Policy Number:**_____

Name of Policy Holder:_____ **Name of Policy Holder:**_____

Relationship to Patient:_____ **Relationship to Patient:**_____

***Policy Holder's SSN:**_____ ***Policy Holder's SSN:**_____

***Policy Holder's Date of Birth:**_____ ***Policy Holder's Date of Birth:**_____

*necessary for insurance identification

*****PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST*****

Authorization, Release & Agreement to Pay For Services Rendered

As a patient, I authorize the healthcare providers at Nephrology Associates, PC to perform diagnostic procedures and treatments as may be necessary for proper medical care.

Medicare: I hereby request that payment of authorized Medicare benefits to or on my behalf for services furnished in or by Nephrology Associates, PC, shall be made to the clinic and I specifically assign such benefits to the clinic. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. I understand that payment for certain services not deemed medically necessary are not authorized under the Medicare/Medicaid Program and that I shall be responsible for such charges unless other third party coverage is available.

Insurance: I hereby assign Nephrology Associates, PC all rights, benefits, and interest under any insurance policy, health plan, or third party payer liable to me, in consideration for services rendered by the provider. I hereby authorize payment to Nephrology Associates, PC by any insurance policy, health plan or third party payer for treatment received. Secondary third party payer insurance claims will not be automatically filed by Nephrology Associates.

Financial Responsibility: I understand that I am financially responsible to Nephrology Associates, PC for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, health plan or other third party payers are due and payable at time of service. I understand, following collection of insurance payment after filing on my behalf, I will receive a statement from Nephrology Associates, PC for either the remainder of amount on my deductible or non-covered services, and that payment is expected. I understand that Nephrology Associates, PC reserves the right to seek the services of a reputable collection agency if statements go unanswered. I agree that in the case of default of payment and, if my account is placed in the care of a collection agency or attorney for collection or suit, all collection fees, finance charges, attorney fees, costs and other expenses will be paid by me.

Non-Certification: I hereby agree that as the policyholder/beneficiary of insurance, health plan or other third party payer, I am responsible for assuring certification is obtained from the insurance company, third party administrator or health plan for the procedure date. If certification is not obtained, I further agree that in the event the insurance health plan or other third party payer denies either all or part of the payment on the account, I will pay the account in full upon demand from Nephrology Associates, PC.

Consent for release of Health Information for Billing and Payment Purposes: I consent to the release of my health information (medical records, medical results, and any and all other health information) by Nephrology Associates, PC or any physician or provider involved in my care for the purpose of billing, claims management, medical data processing, reimbursement, certification to any insurance company, third party payer, health plan or government agency necessary for the billing and payment of my account.

_____ _____

Patient Signature Date

Notice of Communication Methods Used in Patient Care

I acknowledge that there may be communication between staff and healthcare providers regarding my treatment that includes but is not limited to phone conversations, voice mail, email, facsimile, and text messages. I further acknowledge electronic mail (email), facsimile, and text messaging can be a useful tool in the practice of medicine and can be very beneficial and efficient in communicating necessary medical information between healthcare providers regarding my care and treatment. However, these means of communication have some limitations, including the remote possibility of breaches of privacy and confidentiality. It is further understood that every effort is made by Nephrology Associates, PC, its healthcare providers and staff to secure any and all protected health information.

_____ _____

Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, do hereby acknowledge receipt of a copy of
Name (Please Print)
the Notice of Privacy Practices of Nephrology Associates, PC. I understand that the Notice describes the uses and disclosures of my protected health information by Nephrology Associates, PC and informs me of my rights with respect to my protected health information. I further acknowledge Nephrology Associates, PC's right to modify the practices outlined in the Notice of Privacy Practices without additional notice.

_____ _____

Patient Signature Date

In the event this request is made by the individual's personal representative:

_____ _____

Personal Representative Signature Date

_____

Personal Representative's Legal Authority

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Date:_____

Medical Records Release Form

Physician or Medical Facility Name

I hereby grant permission to disclose and deliver any and all information to:

NEPHROLOGY ASSOCIATES, P.C.

T. Jason Dunn, D.O. Christopher J. LeBrun, M.D. Angela M. Riley, M.D.

Laura Ferguson, CFNP Ashli Dunn, CFNP

- ☐ **Complete Case History**
- ☐ **Progress Notes (most recent) (last 6 months) (last year)**
- ☐ **Lab Work (most recent) (last 6 months) (last ye ar)**
- ☐ **Hospital Records (including History & Physical / Discharge Summary)**
- ☐ **Radiology Reports (including Echo, Ultrasound, EKG, CT, MRI)**
- ☐ **Other: _____**

Patient: _____

Patient or Guardian Signature: _____

Address: _____

Date of Birth:_____ Social Security#:_____

Relationship if not patient: _____

Witness Signature: _____