**Renal Care Consultants, P.L.**
**4641 S. Clyde Morris Blvd, Port Orange, FL 32129**
**Phone: 386-322-6212 Fax: 386-322-6212**



## Patient Information Form:

Name: _____
DOB: _____ Sex: ☐ Male ☐ Female Social Security #: _____
Address: _____
Phone: _____ ☐Hm ☐Wk ☐Cell
Phone: _____ ☐Hm ☐Wk ☐Cell ☐ Fax

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other

Referring Physician: _____
Phone: _____ Fax: _____

**Race:**
☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Black or African American
☐ White
☐ Other: _____
☐ Prefer No Answer

**Language:**
☐ English
☐ Spanish
☐ French
☐ Other: _____

**Patient Employment:**
☐ Employed ☐ Retired ☐ Unemployed ☐ Disabled
Employer: _____
Employer Phone: _____
Employer Address: _____ City: _____
State: _____ Zip Code: _____

**Guarantor:** (where bill is to be mailed)
☐ **Check if same as patient:** ***Guarantor:*** _____
Relationship to Patient: _____
Phone: _____
Address: _____
City: _____
State: _____ Zip Code: _____

**Doctor and Pharmacy Information:** List all Doctors Patient sees:
Name: _____ Phone: _____
Name: _____ Phone: _____
Pharmacy: _____ Phone: _____

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**Insurance Information:**

(1) Insurance Carrier: _____
Mailing Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____
Subscriber ID #: _____ Group Name or #: _____
Insured Party Name: _____

(2) Insurance Carrier: _____
Mailing Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____
Subscriber ID #: _____ Group Name or #: _____
Insured Party Name: _____

**I/we, the undersigned agree to be financially responsible for the charges incurred by the patients and to make payments upon receipts of the periodic statements for the patient. In the event of non-payment, I/we agree that if the account is referred to an agency for collection I/we shall be required to pay all the collections expenses.**

**Signature: _____ Date: _____**

**IF YOUR INSURANCE REQUIRES AN AUTHORIZATION, PLEASE BE SURE YOU HAVE ONE CURRENT ON FILE OR YOU MAY NEED TO RESCHEDULE YOUR APPOINTMENT.**

**Emergency Contact Information:**

(1) Name: _____ Relationship: _____
Address: _____ City: _____
State: _____ Zip Code: _____
Phone: _____ Cell: _____

(2) Name: _____ Relationship: _____
Address: _____ City: _____
State: _____ Zip Code: _____
Phone: _____ Cell: _____

I have voluntarily provided the above contact information and authorized Renal Care Consultants, P.L. to contact any of the above on my behalf in the event of an emergency.

Signature: _____ Date: _____

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**Acknowledgement of receipt of "Notice of Privacy Practices"**

In this Notice "you(r)" means you, and/or, your minor dependent that is being treated.

As required via the federal HIPAA regulations (Health Insurance Portability and Accountability Act) the providers at our medical practice, along with its nursing and administrative staff, under the guidance of the Physician(s), may share you(r) health information for the purposes of treatment, payment, and health care operations.

I understand that my health information may be used for the purposes of treatment, payment, and health care operations such as (but not limited to):

A. Sharing my health information among providers (within and outside our medical practice), on a need to know basis, in order to medically treat me.

B. Using my health information for medical billing purposes, including providing referrals to medical specialists, when necessary and appropriate.

C. Sharing my health information with health insurance firms, government agencies, or other claims payers that request information related to benefits determinations, medical claims filed for visits, treatments, admissions, and other billing matters.

D. Using my health care information for health care operations, including monitoring the quality of care, audits, surveys, and carrying out other medical practice business and administrative activities.

E. My permission is given today for any medical treatment including, but not limited to, examination, injections, diagnostic testing or medical procedures as may be deemed advisable by members of this Medical Center.

I understand that all reasonable efforts will be made to protect the privacy of my health information whether maintained as a paper file or electronic file, and regardless of how it is communicated (verbally, or via fax, paper, or electronically).

I have been given the opportunity to read the "Notice of Privacy Practices" which outlines in more detail how my health care information is used and shared with others. The "Notice of Privacy Practices" explains when I need to give further approval for the providers to use my health information or share it outside of the medical practice, and when my permission is not needed for the providers to use my health information or share it outside of the medical practice (such as: required by law, public health activities, and so forth).

I understand that this medical practice has reserved the right to change the "Notice of Privacy Practices" at any time. I may obtain a current copy of the "Notice of Privacy Practices" by contacting the Privacy Officer of this medical practice.

My signature below constitutes my acknowledgement that I have been provided the opportunity to read and obtain a copy of the "Notice of Privacy Practices".

_____ _____

Signature of adult patient or a minor patient's parent or guardian Date

_____

Print the signer's full name

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## HIPPA Release of Information:

TO: _____

Patient: _____

D.O.B: _____

This form is a signed authorization by the patient to release there medical records:

Please include the following records:

☐ Pathology Reports ☐ U/S / CT / MRI reports

☐ History Reports ☐ Consultations/ Chart Notes

☐ Lab Work (1 year) ☐ Operative Reports

☐ Other _____

Signature: _____
Parent/ Guardian

Date: _____

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## Office Policy – Please Read Carefully

We are providers for several PPO and HMO insurance plans and will be happy to file your claim for you. Co-payments are due prior to seeing the physician at the time of service. You are responsible for obtaining any necessary referral or authorization from your primary care physician. You are responsible for any non-covered charges. If you're insurance does not make payment within 45 days, you may be asked to call them for the status of the claim.

Frequently, Insurance companies may require additional information from the patient before processing a claim. If you receive such information in the mail, please fill out the form and mail is back to your insurance company as quick as possible. Failure to do so will make you responsible for the entire bill regardless of our contact status. We will except payment of the deductable and coinsurance amounts at the time of service, or proof that your deductible has been met. We allow 60 days for processing your insurance claims. At the end on that time, if your Insurance has not paid; the entire balance becomes your responsibility.

### Medicare

Renal Care Consultants, P.L. accepts assignment for our Medicare patients. We file with Medicare on your behalf but the co-payment is expected at time of service which is 20% of the Medicare allowable. If your deductable is not met we will collect in full for services rendered.

### Medicaid

Renal Care Consultants, P.L. will file claims to Medicaid on your behalf. You must present a current copy of your Medicaid card each visit.

### No Show Policy

Renal Care Consultants, P.L. implements a NO SHOW policy. If a patient does not cancel or reschedule their appointment within 24 hours of the appointment date a $30.00 charge will be added to their account.

### Notice of Privacy Practices

I have received this Office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

If your account is over 120 days old (4 month) and there has not been any effort to pay the balance, the account will be reported as a bed debit to the Credit Bureau.
Please sign below that you have read this office policy and agree to it. If there is a problem, please speak to the Office Manager before seeing the doctor.

Print Name: _____ Date: _____

Signature: _____

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**Name:** _____ **DOB:** _____

**PLEASE LIST ALL OF YOUR MEDICATIONS THIS INCLUDES OVER THE COUNTER MEDICATIONS, VITAMINS AND SUPPLIMENTS.**

| Medication | Dose | Frequency |
|---|---|---|
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**List any allergies/ reactions you may have.**

_____
_____
_____