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Home Phone:_____ Today's Date:_____

PATIENT INFORMATION

Name_____ Soc. Sec.#_____
Last Name First Name Initial

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Fax_____ # E-Mail_____

Single____ Married____ Widowed____ Separated____ Divorced____ Sex M☐ F☐ Age____ Birthdate_____

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

By whom were you referred?_____

In case of emergency who should be notified?_____ Phone_____
Name Relation to Patient

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec.#_____

Address (if different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents covered under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (if different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Subscriber Employed by_____ Business Phone_____

Insurance Company_____ Soc. Sec.#_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents covered under this plan_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Dr._____ insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

CALIFORNIA KIDNEY SPECIALISTS

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Operations

I _____, understand that as part of my health care, California Kidney Specialists, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payor can verity that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that California Kidney Specialists Group, is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that California Kidney Specialists Group, receives the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should California Kidney Specialists Group, change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information.

_____

_____

_____

I understand that my medical record can be used for research purposes. As a result, I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature Date

FOR OFFICE USE ONLY

☐ Consent received by _____ on _____

☐ Consent refused by patient, and treatment refuse as permitted.

☐ Consent added to the patient's medical record on _____.

CALIFORNIA KIDNEY SPECIALIST

CONSENT TO DISCLOSE MEDICAL HEALTH INFORMATION

I _____ GIVE AUTHORIZATION TO

CALIFORNIA KIDNEY SPECIALIST TO DISCUSS MY MEDICAL INFORMATION TO THE FOLLOWING PEOPLE LISTED BELOW:

• NAME:	• RELATIONSHIP:	• TELEPHONE:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

- DATE: _____

- SIGNATURE: _____