The Kidney Clinic, LLC

2386 Clower Street | Suite C-105 | Snellville, GA 30078
1501 Milstead Road | Suite 150 | Conyers, GA 30012
10132 Carlin Drive | Covington, GA 30014
3370 Sugarloaf Pkwy | Suite A1 | Lawrenceville, GA 30044
4805 Lawrenceville Hwy | Suite 320 | Lilburn GA 30047

Mazen Abdalla, MD, FACP
Divakar Jammalamadaka, MD
Sherria Jasper, NP-C

☎ (678) 344-0334 🖷 (678) 344-0343

Patient Information

Last Name: _____ First Name: _____ MI: _____ Suffix: ____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____

Gender: _____M _____F Marital Status: _____S _____D _____M _____W

Address: _____ City: _____

State/Zip: _____,_____ Home Phone: (_____)_____-_____

Work: (_____)_____-_____ Cell: (_____)_____-_____

Preferred Contact: ____Home ____Cell ____Work Is Patient a Referral? ____Y ____N

Referring Provider: _____ Primary Care Provider: _____

Emergency Contact: Name: _____

Phone: (_____)_____-_____ Relationship: _____

Pharmacy Name: _____ Number: (_____)_____-_____

Insurance

Primary Insurance: _____

Plan Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: _____/_____/_____

Patient Relationship to Policy Holder: _____Self _____Spouse _____Child _____Other

Secondary Insurance: _____

Plan Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: _____/_____/_____

Patient Relationship to Policy Holder: _____Self _____Spouse _____Child _____Other

I herby authorize my insurance company benefits to be paid directly to the physician. I realize I am responsible to pay for any non-covered services. I hereby authorize the release of pertinent medical information to the insurance company.

_____ _____/_____/_____
Patient or Legal Representative's Signature Date

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RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby authorize the medical office of THE KIDNEY CLINIC including the staff and agents, to release any and all medical information about me, including but not limited to my medical records, that is necessary to process any claims for insurance or reimbursement and to communicate with other medical personnel and medical facilities to coordinate my care.

I, the undersigned, also authorize THE KIDNEY CLINIC to obtain my medical records from all other treating physicians, hospitals and other facilities. I also authorize the release of my Protected Health Information from all other treating physicians, hospitals and other facilities to THE KIDEY CLINIC.

This authorization shall remain in effect until I specifically notify THE KIDNEY CLINIC in writing that I am revoking this authorization.

Please Print Name: _____

Date of Birth: _____

Please Sign Name: _____

Date: _____

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Insurance Authorization / Consent For Treatment

I, the undersigned, hereby authorize the medical offices of The Kidney Clinic including but not limited to Physicians, staff and agents, to release any and all medical information about me, including but not limited to my medical records, that is necessary to communicate with and to process any claims for insurance or reimbursement.

Payment for services provided is due at the time services are rendered. We will submit a claim for you to any third party or insurance carrier with whom we contract. Any fees not payable by the third party or insurance carrier, and any non-covered services, are the patient's responsibility.

I hereby also authorize and assign payment of any and all medical benefits to The Kidney Clinic for services rendered and authorize my insurance company on files' benefits to be paid directly to the physician.

I hereby give consent for medical treatment by the physicians and the staff of The Kidney Clinic.

This authorization shall remain in effect until I specifically notify The Kidney Clinic in writing that I am revoking this authorization.

Please Print Name: _____

Date Of Birth: _____

Please Sign Name: _____

Date: _____

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HIPAA PRIVACY NOTICE CONSENT FORM

I understand and have been provided with a copy of The Kidney Clinic's "Notice of Privacy Practices".

The Kidney Clinic reserves the right to make changes to their Privacy Notice and revised copies are available. By signing this form I acknowledge that I have been afforded the opportunity to consider The Kidney Clinics Notice of Privacy Practices prior to signing this consent and making healthcare decisions.

I authorize The Kidney Clinic to release medical and financial information, including any or all reports, records, bill for services rendered or opinions found in my medical chart, with respect to treatment to any alternative healthcare or insurance provider.

The Kidney Clinic maintains patient medical records on electronic media which may be accessible to any physician or healthcare provider participating in my current or future care.

Medical records are disclosed according to applicable GA State and Federal laws, and the provisions of this consent.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:

Can we leave test results on your answering machine? _____No _____Yes Ph#_____

You may disclose my medical information to the following family members/friends:

_____ Patient ONLY **OR**

_____	_____	_____
Please Print Name	Relationship	Phone Number
_____	_____	_____
Please Print Name	Relationship	Phone Number
_____	_____	_____
Please Print Name	Relationship	Phone Number

I acknowledge that I have received a copy of The Kidney Clinic's "Notice of Privacy Practices".

_____	_____
Signature of patient or Legal Guardian	Date