The Kidney Clinic, LLC

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Patient Information

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

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Gender: _____M _____F

Marital Status: _____S _____D _____M _____W Race: _____ Ethnicity:_____

Language: _____ Interpreter Required: _____Yes _____No

Address: _____ Apt/Suite: _____

City: _____ State, Zip: _____, _____ County: _____

Home: (_____)_____-_____ Cell: (_____)_____-_____

Preferred #: _____Home _____Cell _____Work Text Messages: _____Opt In _____Opt Out

Email: _____My Chart: _____Opt In _____Opt Out

Employment Status: ____Full-time ____Part-time ____Self ____Disabled ____Military ____Retired ____Unemployed

Employer Name: _____Work: (_____)_____-_____

Referring Provider: _____ Ph: (_____)_____-_____

Primary Care Provider: _____ Ph: (_____)_____-_____

Insurance

Primary Insurance: _____

ID Number: _____ Group Number: _____

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

Patient Relationship to Policy Holder: _____Self _____Spouse _____Child _____Other

Secondary Insurance: _____

ID Number: _____ Group Number: _____

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

Patient Relationship to Policy Holder: _____Self _____Spouse _____Child _____Other

I hereby 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.

_____ _____

Signature of Patient or Legal Guardian Date

RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby authorize the medical office of THE KIDNEY CLINIC including the staff and agents, to release 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 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.

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 KIDNEY CLINIC.

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

Name of Patient: _____ Date of Birth: _____

The patient above is requesting a copy of his/her records to be sent to:

The Kidney Clinic, LLC
2386 Clower Street, C-105, Snellville, GA 30078
Fax: 678-344-0343 or 678-696-1990

I am authorizing my medical records to be released to the above-mentioned Doctor/Hospital/Facility. I do hereby consent and authorize the office to release copies of my medical records, including current and previous medical records to other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for release of alcohol, drug, psychiatric and psychological information and any other information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and AIDS-related syndromes. I agree that a copy of this release or fax of this release shall be as valid as the original release. Please send copy of all required information as soon as possible via fax or to the address listed above.

_____ _____
Signature of Patient or Legal Guardian Date

INSURANCE AUTHORIZATION

I, the undersigned, hereby authorize the medical offices of THE KIDNEY CLINIC including but not limited to Physicians, staff, and agents, to release 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 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 allow THE KIDNEY CLINIC to file for insurance benefits to pay for the care I receive.

I understand that:

- THE KIDNEY CLINIC will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

CONSENT FOR TREATMENT

I hereby give consent for medical treatment by the physicians and the staff of THE KIDNEY CLINIC. Such treatment may include, but is not limited to, diagnostic procedures, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment, and course of care.

I acknowledge that my treatment is intended to address specific illnesses and is not intended as a substitute for a primary care physician and that no guarantee can be made or has been made as to the results of treatments or examinations at THE KIDNEY CLINIC.

In the event an employee has a needle stick or otherwise is exposed to my blood or bodily fluids, I consent to testing for HIV or Hepatitis C & B.

I understand that I have the right to refuse any procedure or treatment and that I have the right to discuss all medical treatments with my clinician.

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

Patient Name:_____ Date of Birth:_____

_____ _____

Signature of Patient or Legal Guardian Date

HIPAA PRIVACY NOTICE CONSENT FORM

I understand and (upon request) 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 CLINIC's Notice of Privacy Practices prior to signing this consent and making healthcare decisions.

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.

PATIENT COMMUNICATION PREFERENCES

Patient Name:_____ Date of Birth:_____

Our office will need to contact you to schedule and/or reschedule appointments, relay lab and/or test results and other such administrative issues. To ensure that your privacy is fully maintained, please select the method(s) by which our office may contact you.

	May we leave a message?	May we leave results?
Home Phone:_____	_____Yes / _____ No	_____Yes / _____ No
Cell Phone:_____	_____Yes / _____ No	_____Yes / _____ No
Fax:_____	_____Yes / _____ No	_____Yes / _____ No
Email:_____	_____Yes / _____ No	_____Yes / _____ No

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:

I give authorization for THE KIDNEY CLINIC to discuss my medical records with: (example: spouse, child, friend,caregiver). Please do not list your other physicians as we do not need permission to discuss your care with them. These listed contacts will also be used in case of an emergency.

_____ Patient ONLY ****OR****

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

_____ _____

Signature of Patient or Legal Guardian Date

MEDICATIONS / ALLERGIES / PHARMACY

For your convenience, The Kidney Clinic may send prescriptions electronically to participating pharmacies:

What is the name, address, and phone number

Name: _____ Phone #:_____

Address: _____

_____

List your allergies: _____No allergies that I know of

ALLERGY	REACTION

List you medications, prescriptions, over-the-counter, and herbal: _____ No Medications

MEDICATION NAME	DOSAGE	HOW OFTEN