***Southern Kidney Specialists***

**Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_**

**New Patient Registration Form**

|  |
| --- |
| PRIMARY CARE PHYSICIAN NAME: PHONE NUMBER: |
| REFERRING PHYSICIAN NAME: PHONE NUMBER: |
| PATIENTS FIRST NAME: MIDDLE: LAST: |
| DATE OF BIRTH: SSN: GENDER: MALE □ FEMALE □ |
| ADDRESS: CITY: STATE: ZIP CODE: |
| HOME PHONE: ( ) CELL PHONE: ( ) |
| CURRENT MARITAL STATUS: SINGLE□ MARRIED□ DIVORCED□ WIDOWED□ |
| EMPLOYER NAME: WORK PHONE: |
| EMERGENCY CONTACT NAME: PHONE NUMBER: |
| NAME OF RESPONSIBLE PARTY FOR PAYMENT (If not Patient): PHONE NUMBER: ( ) |
| ADDRESS: CITY: STATE: ZIP CODE: |
| SPOUSE’S NAME: SPOUSE’S DATE OF BIRTH: |
| SPOUSE’S SSN (If insured through Spouse): |
| **POLICY HOLDER INFORMATION** (Information applies to the person whose name the insurance falls under**)** |
| **PRIMARY** INSURANCE COMPANY NAME**:** |
| INSURED NAME: DATE OF BIRTH: |
| EMPLOYER: SSN: |
| POLICY OR ID NUMBER: GROUP NUMBER: |
| ADDRESS FOR CLAIMS: |
| CITY: STATE: ZIP CODE: |
| **SECONDARY** INSURANCE COMPANY NAME: |
| INSURED NAME: DATE OF BIRTH: |
| EMPLOYER: SSN: |
| POLICY OR ID NUMBER: GROUP NUMBER: |
| ADDRESS FOR CLAIMS: |

**E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  |  | **SOUTHERN KIDNEY SPECIALISTS, L.L.C**  **PLEASE LIST PRESCRIPTIONS AND ALL OTC MEDICATIONS** |
| **PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

|  |  |  |
| --- | --- | --- |
| **MEDICATION** | **STRENGTH** | **INSTRUCTIONS ON HOW TO TAKE MEDICATION** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **ALLERGIES:** | | |
|  |  |  |
|  |  |  |

**Consent to Treatment**

**and Payment Agreement**

This consent to treatment, consent to release of health care information and payment agreement (“**Agreement**”)pertains to the treatment of the signatory below (the “**Patient**”) at Southern Kidney Specialists (the “**Physician Office**”).The patient and/or the individual signing this agreement on the patient’s behalf hereby agree to comply with all clinical visit requirements of the physician office. For purposes of this agreement, “I,” “me”, “my” and “myself” refer to the patient, the patient’s legal representative and/or the patient’s principal obligor, as appropriate. As part of the course of my care and/or diagnosis and treatment of my medical condition, I voluntarily consent to receive services and care from the physician office.

**Payment**

**ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE**

As a courtesy to our patients, we file insurance claims for services rendered. However, patients have full responsibility to pay for all services rendered on their behalf. Southern Kidney Specialist is not responsible for collecting on your insurance claim or for settling a disputed claim. Misunderstandings regarding insurance coverage and policy benefits are matters to resolved between patients and their insurance companies.

**PPO Plans**

If the physician’s office is contracted with your plan, the majority of members covered under this type of plan are still required to make some type of payment for service that is rendered to them. This may be in the form of co-payment, deductible or co-insurance. If your plan has a co-payment or deductible, you will be expected to pay prior to being seen by the doctor. Co-payments, deductibles and co-insurance are requirements of your insurance plan and the physician’s office is required under our contract with these plans to collect these amounts from you.

**POS and HMO Plans**

Most of the members covered under POS and HMO plans also owe co-payments, and members of POS plans may

also owe deductibles and/or co-insurance. Co-payments and deductibles will be collected prior to being seen by the doctor. The physician’s office is required under our contract with these plans to collect these amounts from you.

**Collections**

Southern Kidney Specialists, L.L.C. may turn over delinquent accounts to an independent Collection Agency. Patients will be given ample notice and opportunity to pay balances prior to being assigned to a Collection Agency.

**Assignment of Benefits and Medical Records Release**

I hereby authorize the insurances that I listed to directly pay Southern Kidney Specialist, L.L.C for any benefits due to a result of services rendered. I attest that the insurance information given to you is unexpired. I will pay any and all charges in excess of sums paid by the insurance company. I authorize Southern Kidney Specialists, L.L.C. to release information to the insurance company (ies) for claims submitted on my behalf.

**THE UNDERSIGNED MAY RECEIVE A COPY OF THIS AGREEMENT UPON REQUEST, AND CERTIFIES THAT HE OR SHE**

**HAS READ THIS AGREEMENT AND HAS BEEN ABLE TO ASK QUESTIONS.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name of Patient Printed Name of Witness**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Signature & Date Witness’ Signature & Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Legal Representative/Principal Obligor Legal Representative/Principal Obligor’s Signature & Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient (Self, Legal Representative, Printed Name of Interpreter [if applicable]**

**Principal Obligator, General Agent)**

**SOUTHERN KIDNEY SPECIALISTS, LLC**

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL AUTHORIZATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET TO ACCESS THIS INFORMATION. PLEASE READ IT CAREFULLY.

Southern Kidney Specialist, LLC is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected healthcare information and to provide you with the notice of our legal duties and privacy practices with respect to protected health information. Southern Kidney Specialist, LLC is required by law to abide by the terms in this notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for services rendered and by administrative personnel reviewing the quality of care you receive.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

**Appointment Reminders**

● We may contact you to provide appointment reminders.

**Treatment Information**

● We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Disclosure to Department of Health and Human Services**

● We may disclose medical information when required by United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

**Family and Friends**

● Unless you object, we may use or disclose your medical information to family members, other relatives or close personal friends when the medical information is directly relevant to that person’s involvement with your care.

**Notification**

● Unless you object, we may disclose your medical information to notify a family member, a personal representative or another person responsible for your care, location, general condition, or death.

**Health Oversight Activities**

● We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure of or disciplinary actions, administrative and/or legal proceedings.

**Abuse or Neglect**

● We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

**Legal Proceedings**

● We may disclose your medical information in the course of certain judicial or administrative proceedings.

**Law Enforcement**

● We may disclose your medical information for law enforcement purposes or other specialized government functions.

**Coroners, Medical Examiners and Funeral Directors**

● We may disclose your medical information to a coroner, medical examiner or a funeral director.

**Organ Donation**

● If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

**Public Safety**

● We may use or disclose your medical information to prevent or lessen a serious health or safety by another person or to the public.

**Workers’ Compensation**

● We may disclose your medical information as authorized by laws relating to workers’ compensation or similar programs.

**Business Associates**

● We may disclose your medical information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

HIPAA regulations do not require the Notice of Privacy Practices to include a list of all situations requiring authorization; or a description of recordkeeping for psychotherapy notes.

**AUTHORIZATIONS**

We will not use or disclose your medical information for any other purpose without your written authorization. Once

given, you may revoke your authorization in writing at any time. You may request a revocation of authorization form by

contacting:

Southern Kidney Specialists, LLC

P.O. Box 1800

Luling, LA 70070

(504) 722-9086

**YOUR RIGHTS’ REGARDING YOUR MEDICAL INFORMATION:**

You have the following rights with respect to your medical information:

● You may ask to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

● You have the right to receive communications from us in a confidential manner.

● Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

● You may ask us to amend your medical information. We may deny your request for specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

● You may request a paper copy of this Notice of Privacy for Protected Health Information.

● You have a right to be notified if your confidential personal or healthcare information has been breached.

● You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

Southern Kidney Specialists, LLC

P.O. Box 1800

Luling, LA 70070

(504) 722-9086

**Southern Kidney Specialists, LLC**

**REVISION OF NOTICE OF PRIVACY PRACTICES**

We reserve the right to change the terms of the Notice, making any revision applicable to all the protected

health information we maintain. If we revise the terms of this notice, we will post a revised notice at Southern

Kidney Specialist, LLC and will make paper copies of the revised notice of privacy practices available upon

request.

**ACKNOWLEDGEMENT:**

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Southern

Kidney Specialist, LLC’s notice of privacy practices

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Patient Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative’s Relationship to Patient