

Patient Information Form:

Name: _____
DOB: _____ Sex: Male Female Social Security #: _____
Address: _____
Phone: _____ Hm Wk Cell Phone: _____ Hm Wk Cell
Marital Status: Married Single Divorced Widow
Referring Physician: _____ Phone Number: _____

Texas law requires Health care facilities to ask patients to identify their own race and ethnic background.

Race:

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

Language:

- English
- Spanish
- Indian
- Russian
- Other: _____

Ethnicity:

- Hispanic
- Non-Hispanic
- Prefer No Answer

Patient Employment:

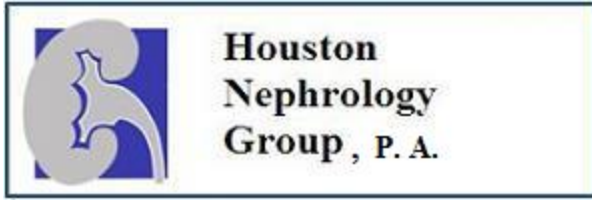
Employed Retired Unemployed Disabled
Employer: _____ Employer Phone: _____
Employer Address: _____ City: _____
State: _____ Zip Code: _____

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 Patients sees:

Name _____ Phone # _____
Name _____ Phone # _____



Name _____ Phone # _____

Pharmacy Name: _____ Phone # _____

Insurance Information:

(1) Insurance Carrier: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Subscriber ID #: _____ Group Name or #: _____

Insured Party Name: _____

(2) Insurance Carrier: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Subscriber ID #: _____ Group Name or #: _____

Insured Party Name: _____

This is to certify that I/we, the undersigned, hereby consent to and authorize the administration and performance of all treatments and operations, and the administration of any anesthetics, which, is the judgment of my physician maybe considered necessary or advisable.

I/we, the undersigned agree to be financially responsible for the charges incurred by the patients and to make payments upon receipt 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 pall all the collection expenses.

Signature _____ Date _____

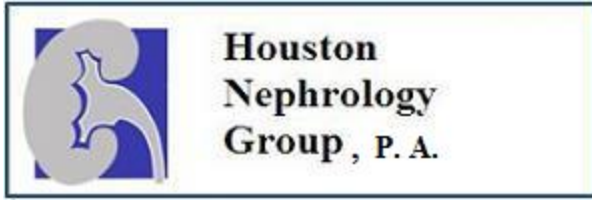
IF YOUR INSURANCE REQUIRES AN AUTHORIZATION, PLEASE BE SURE YOU HAVE ONE CURRENT ON FILE OR YOU MAY NEED TO RESCHEDULE YOUR APPOINTMENT.

Emergency Contact Form

Patient's Name: _____ Date of Birth: _____

Emergency Contact Information:

1) Name: _____ Relationship: _____



Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Cell: _____

(2) Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Cell: _____

I have voluntarily provided the above contact information and authorize Houston Nephrology Group, P.A. to contact any of the above on my behalf in the event of an emergency.

Signature: _____ Date: _____

HIPAA Release of Information

Patient's Name: _____ Date of Birth: _____

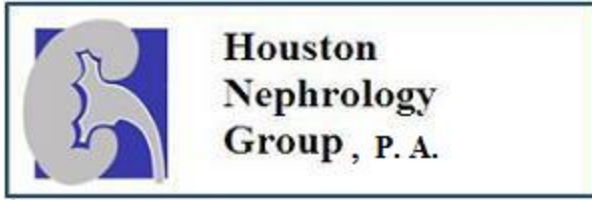
Appointment Information:

Please check all of the following message delivery methods that are available in case we can not reach you. Please include your daytime/work telephone number. For each number, please authorize name(s) with whom we may arrange or confirm your appointment information.

Home Phone # _____ Daytime/Work phone # _____

Mobile phone # _____

a. Can we leave a detailed message on this voicemail? YES / NO



b. We may arrange or confirm your appointment with:

Self only Spouse Mother Father Child Other

Name of child/other: _____

Medical Information:

With whom may we discuss or disclose your medical information?

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

I have received a copy of the Notice of Privacy Practices from Houston Nephrology Group, P.A. I will inform Houston Nephrology Group, P.A. with any changes of the above disclosure information.

Patient's Signature _____ Date _____

Memorial City Prof. Bldg. III
915 Gessner, Suite 360
Houston, TX 77024
Tel: 713-468-5440 ~ Fax: 713-973-0778

N. Cypress Prof. Bldg. I
21216 NW Frwy., Suite 410
Cypress, TX 77429
Tel: 281-571-8090 ~ Fax: 281-571-8095

Authorization to Release Medical Information:

I authorize Houston Nephrology Group, P.A. to Release to Receive from:

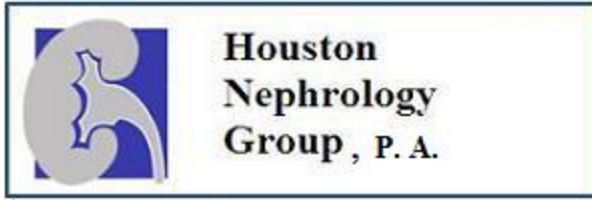
Person or Organization: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____
Fax: _____

Information/copies from the Medical Records of:

Patient: _____ DOB: _____
Social Security: _____ Date of Service (s): _____

Information to be released:

Emergency Room Radiology Report Lab Work Radiology Film



I understand that I may revoke this authorization in writing at any time, except to the extent that action has been reliance on it and that in any event his authorization shall expire (180) days from the date of my signature unless specified in writing here: _____

I understand that if the recipient authorized to receive the information is not covered entity, e.g. Insurance Company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

To the Party Receiving this Information: This information has been disclosed to you from records that confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

For Patient Records Applicable Under Federal Law 42 CFR PART 2:

Signature/Legal Authorized Representative: _____

Print Name: _____ Date: _____

Witness: _____ Date: _____

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 it back to your insurance company as quick as possible. Failure to do so will make you responsible for the entire bill regardless of our contract status. We will expect payment of the deductible and coinsurance amounts at the time of service, or proof that your deductible has been met. We allow 60 days for processing of your insurance claims. At the end of that time, if your Insurance has not paid; the entire balance becomes your responsibility.

Medicare

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

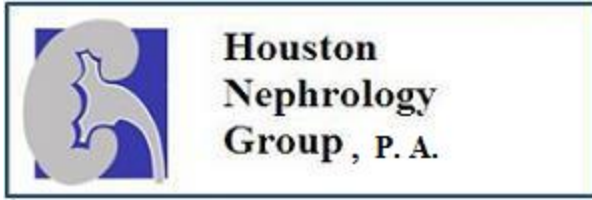
Medicaid

Houston Nephrology Group, P.A. will file claims to Medicaid on your behalf. You must present a current copy of your Medicaid card at each visit.

No show Policy

Houston Nephrology Group, P.A. implements a NO SHOW policy. If a patient does not cancel or reschedule their appointment within 24 hours of the appointment date a \$25.00 charge will be added to their account.

Notice of Privacy Practices



I have reviewed 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 months) and there has not been any effort to pay the balance, the account will be reported as a bad debt 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: _____