Nephrology Associates of Tidewater

PATIENT INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex:**
City:	**E-Mail:**
State: Zip:	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**
Language Spoken:	**Do you consider yourself Hispanic/Latino?** ☐ **Yes** ☐ **No**
Primary Care Physician:	**Referring Physician:**
Race (circle): American Indian or Alaska Native, Asian, African American, Native Hawaiian, Caucasian, Other Pacific Islander Other ____________________ ____________________ **Marital Status:** ____________________ **Spouse's Name:** ____________________	**Local Pharmacy:** ____________________ **Address:** ____________________ ____________________ **PH#**__________**Fax#** __________ **Mail-In Pharmacy:** ____________________ **Address:** ____________________ ____________________ **PH#**__________**Fax#**__________

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**

Financial Agreement: I/We______________________(Patient) and______________________(Guarantor) agree to be financially responsible for the cost of all medical services rendered to the Patient by *Nephrology Associates of Tidewater, Ltd.* The cost of these services shall be in accordance with the fee schedule in effect at the time of service. The undersigned agree(s) to pay, in addition to the doctor's fees, any and all costs of collecting the amount due on that date. I/We acknowledge receipt of a copy of this agreement and fully agree to and understand the condition set forth regardless of any insurance coverage, court litigation, or other party involvement.

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Nephrology Associates of Tidewater when he accepts assignment.

Authorization To Release Medical Information: I hereby authorize my Provider, Nephrology Associates of Tidewater to release any information necessary for my course of treatment.

______________________ Signed (patient or parent if minor) ______________ Date

______________________ Witness ______________ Date