

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:	Referring Physician:
Specialty Care Team:	
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:
Cell Phone#:	Zip:

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, the fees of any collection agency, which will be added to the account at the time it is placed with a collection agency and may be based on a percentage of a maximum of 25% of the debt, and all costs, and expenses, including reasonable attorney fees, incurred in such collection efforts. 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, Ltd., to release any information necessary for my course of treatment.

Signed (patient or parent if minor)

Date

Witness

Date